VA'S PLANS FOR IMPLEMENTING HEALTH CARE REFORM AND CURRENT AND FUTURE CONSTRUCTION PLANNING AS IT RELATES TO HEALTH CARE REFORM IN THE VA

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE
OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

MARCH 23, 1994

Printed for the use of the Committee on Veterans' Affairs

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WEDNESDAY, MARCH 23, 1994

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 9:43 a.m., in room 334, Cannon House Office Building, Hon. J. Roy Rowland [chairman of the subcommittee] presiding.

Present: Representatives Rowland, Long, Filner, Bishop, Kreidler, Smith, Stump, Bilirakis, Everett and Buyer.

OPENING STATEMENT OF CHAIRMAN ROWLAND

Mr. ROWLAND. I apologize to my colleagues and everyone else here for the delay this morning.

The subcommittee will come to order. Our subcommittee has held a series of hearings on VA's role under a national health care reform. Our last two hearings on that subject focused on the VA role as envisioned in H.R. 3600. Of course, the Congress has a number of health care reform proposals before it. Some take an incremental approach, while others would go further. Veterans are looking to this committee, however, to build on Title VIII of H.R. 3600 and improve it as best we can. Moreover, if we fail to take up and attempt to improve the Administration's veterans' provisions, we face the possibility that they will be adopted as introduced. Regardless of our individual views on other elements of the Administration's bill, a national health care reform bill provides this committee an opportunity we have never had before, and are unlikely to see again. It gives us an opportunity to establish meaningful eligibility reform and a stable funding base to support it. I have been working on that with Chairman Montgomery and hope to have a package that we can begin to mark up in April.

As we move toward our role in marking up legislation, we want to learn more about how VA would carry out its proposed role under health reform. We need to understand how VA would transform and restructure itself. How will its delivery system change? How will it establish business plans and manage business operations? How will it reorganize itself? How will it balance a new role as a provider of a basic benefits package with its traditional role

as a provider of specialized services which may not be covered under that basic package?

In posing those questions, I want to emphasize that this hearing is aimed at taking us beyond the language and specific elements of H.R. 3600. That legislation, as introduced, simply represents our starting point. We need to look beyond aspects of that bill with which we may disagree to broader questions of how VA would go about changing the way it does business if some far-reaching health reform legislation were enacted. While there are differences among us on the merits of competing health reform bills, I believe most of us see a need for sweeping changes in the VA health care delivery. It is not realistic to think we can achieve such changes without a broad vehicle like a national heath reform bill. Regardless of the ultimate shape of such legislation, VA's planning work on implementing system reforms is important to our deliberations.

As a related matter, this committee has a responsibility to develop authorizing legislation for major medical construction projects. In my view, that responsibility compels us to consider the implications which a VA role in health care reform has for construction planning and the establishment of construction priorities.

Because this hearing focuses on the extensive planning work VA has only recently completed, and because the Department has not yet released those plans, we have invited the Department witnesses to discuss that planning process and the strategies for the future. We look forward to their testimony.

I now recognize Ranking Member, Mr. Chris Smith.

OPENING STATEMENT OF HON. CHRISTOPER H. SMITH

Mr. SMITH. Thank you very much, Mr. Chairman. Today the subcommittee will hear testimony from the VA witnesses regarding VA's plan for implementation of national health care reform. It is my understanding, Mr. Chairman, that in January the VA convened over 200 participants in work groups to detail strategies to enable VA to better position itself in this era of health reform. VA is to be commended for their forward thinking approach as there are many steps the VA needs to take in order to make the kind of improvements which will help ensure its survival. These changes need to be made regardless of what the Congress ultimately enacts for the rest of the Nation.

As the VA formulates its plans, it is my hope that the agency does not solely dedicate its efforts towards the enactment of H.R. 3600, the Health Security Act. As the Chairman has pointed out, the fate of that particular legislative approach is clearly uncertain. Rather, it is a great deal more beneficial to Members of this Committee if the VA examines the types of reforms necessary to take the VA into the future as well as to meet the needs of the veterans it now serves.

In order for the VA to survive and to contribute as a viable contributor to this Nation's health care system, the Department must identify ways in which it can become more customer-oriented. It must develop sound financial planning strategies and revise its management structure both centrally and locally. Instead of expecting veterans to seek out the VA, the VA must begin to seek out the veteran. In so doing, the VA must begin to move away from

large, vertically-integrated hospitals and place more emphasis on smaller, community-based health care delivery options. Finally, the VA must adapt new ways of delivering health care and shift from its current emphasis on highly specialized acute hospital care to an increased reliance on primary and noninstitutional care.

Such changes, obviously, will not come easy. The VA has evolved into its present culture after more than six decades. However, Mr. Chairman, I am encouraged by the willingness of the Secretary of the Veterans Affairs, Jesse Brown, to lead VA toward a new direction. It will take hard work; it will take a lot of cooperation within the Department, within the Congress, and within the veterans community to aid VA in this enormous transition.

Secondly, Mr. Chairman, we will discuss the VA's construction process and whether or not we can have any faith whatsoever in the planning process VA employs to ensure that the system is designed and structured to care for its veterans now and in the future. Next month, this Subcommittee will be expected to report to the Full Committee our recommendations for construction priorities for fiscal year 1995. Yet, the very limited construction dollars dramatically inhibit the number of projects this Committee will be able to authorize. Simply put, the dollars allocated for major medical construction come no where near meeting the enormous needs of the department.

Again, I thank you for convening this hearing and look forward to the witnesses.

Mr. ROWLAND. Thank the gentleman.

The gentleman from Arizona, Mr. Stump.

OPENING STATEMENT OF HON. BOB STUMP

Mr. STUMP. Thank you, Mr. Chairman, and I want to commend you for holding this very timely hearing on implementation of national health care reform and VA construction.

These topics are interrelated, and I am very concerned about them both.

I understand the VA's implementation plan has not yet been approved by Secretary Brown. I hope this will happen soon and look forward to the testimony from today's witnesses.

As you know, Mr. Chairman, I am extremely frustrated by VA's construction budget and the priority process.

Cutting the construction budget by 70 percent is no way to prepare the VA for competition with the private sector. In addition to unacceptable cuts in construction, this budget continues to neglect many Sunbelt states which have experienced increased demand for services due to migration patterns of veterans. The 1990 census shows that between 1980 and 1990 the veteran population in 34 states decreased while it increased in 16 states.

Two states lost more than one quarter of a million veterans each, and another five states lost more than one hundred thousand each.

Florida's veteran population increased by almost 350,000.

My state of Arizona had the second highest increase, gaining more than 88,000 veterans.

Of the 11 states gaining more than 10,000 veterans, nine are in the Sunbelt.

Mr. Chairman, I believe that neither construction dollars nor annual hospital budgets have kept pace over the years with migrating veterans. This situation cannot be corrected in one year, and we will not get it resolved with one hearing.

VA officials have been responding to my questions about these issues and I will continue to share them with you.

Interestingly, some of VA's facilities showing the greatest deficiencies in ambulatory care function are not included in the five-year plan for additional construction projects.

Other projects in states with nearly the highest decrease in veteran population during the 1980s received higher priority scores.

To protect the integrity of this Committee's construction authorization bill, I believe we must do a better job of scrutinizing VA's methodology and conclusions about construction priorities.

I thank you, Mr. Chairman.

Mr. ROWLAND. Thank you.

The gentleman from Florida, Mr. Bilirakis.

OPENING STATEMENT OF HON. MICHAEL BILIRAKIS

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Let me also take this opportunity to commend you for holding this very important hearing today. The health care debate is proceeding rapidly, and it is important that we closely monitor any impact health care reform may have on the Department of Veterans Affairs.

During the time veterans service organizations have been presenting their annual testimony to the House and Senate Veterans Affairs Committees, I, along with, I'm sure, all of us, have met with representatives from our districts. Based on my meetings with these Florida veterans one thing is very clear—they are extremely concerned that the VA health care system will cease to exist if the Administration's health care proposal is adopted.

After years of underfunding, they do not believe the VA will be able to effectively compete with the private sector for patients. They are concerned that the VA's ability to provide services in the areas of long-term care, spinal cord injury, blind rehabilitation and prosthetics will diminish under national health care reform. They are afraid veterans will end up at the back of the line for health care.

Quite frankly, Mr. Chairman, I don't blame them for being anxious about the future of the VA health care system. This subcommittee has held numerous hearings on the impact of national health care reform. To date, I remain unconvinced that the viability of the VA health care system will be protected if an universal health care proposal is adopted.

Indeed, health care reform may become a modern trojan horse for the Department of Veterans Affairs. The Clinton plan, in its present form, will sow the seeds of destruction of an independent health care system for our Nation's veterans. Under the guise of "open market" competition, the plan seeks to match an underfunded VA system against private health care plans that have benefitted from years of double digit increases in revenue. It is simply not a fair fight and we risk disenfranchising our Nation's veteran populations.

We have huge construction backlogs at VA facilities, as others have already said, and yet these facilities are supposed to compete, literally overnight, with private and public sector facilities. We have been denying care to many veterans for years—yet we now expect them to choose an option for care that has been historically unreliable. If this doesn't fly in the face of logic, I am not really sure what does.

In fact, there are already several case studies where national health care reform has led to the demise, and destruction of separate veterans' health care systems. In five Western nations that instituted universal coverage, the VA health care system was eventually dissolved. I don't believe this is what our veterans want, and I know it's not what they deserve.

Veterans in my district and throughout the country are also concerned that the VA will lose its autonomy and its ability to meet the unique health needs of our veterans. Under the Administration proposal, as we know, a national board will set the policies and guidelines for health care plans, as well as the basic benefits package the VA is mandated to provide. This would strip the VA of authority, an ironic result given our recent elevation of the VA to Cabinet status. The plan could also hinder the VA's flexibility to offer veterans all of the services they require and limit the resources available.

The VA health care system is a national asset, and I am committed, and I'd like to think this entire Committee is committed, to ensuring that it continues to be one. I've said this before but I think it deserves repeating: the veterans service organizations that are in the audience this afternoon—I guess I'll say this morning, it's still morning, need to remain diligent. The health care debate is far from over, and it is imperative that you continue to be active players in the ongoing deliberations on health care reform.

Mr. Chairman as always, I look forward to working with you and the other members of the Committee on this important issue.

Thank you.

Mr. ROWLAND. Thank you.

The gentleman from Alabama, Mr. Everett.

OPENING STATEMENT OF HON. TERRY EVERETT

Mr. EVERETT. Thank you, Mr. Chairman, I, too, want to congratulate you for having this hearing.

Mr. Chairman, I've listened with interest to your comments and those of our Ranking Member, Mr. Smith, as well as my other colleagues. In all honesty, I think the VA has been put in a difficult situation given the lack of adequate funding in recent years. I am concerned in particular about the number of veterans in my district who live in rural areas and the lack of community-based clinics to serve them. I'm also concerned about long-term care and options available to them if CBCs are not made available.

Mr. Chairman, I have a statement I want to submit for the record and some questions, too.

Mr. ROWLAND. Without objection.

The gentleman from Indiana, Mr. Buyer.

OPENING STATEMENT OF HON. STEVE BUYER

Mr. BUYER. Thank you, Mr. Chairman. I compliment you for holding this hearing today, not only about Mr. Clinton's health care plan, but also about the VA's construction planning process. Many of us, me in particular, were concerned about the Administration's fiscal year 1995 budget report and the deep cuts in the construction budget. Also, I am concerned about whether or not the VA can insulate itself from political pressures when they set out their priorities for construction projects.

I agree with you, Mr. Chairman, when you said that President Clinton's plan is that starting point. However, if we are all at the starting point, I'd choose not to follow that path on which the President has put his plan because of some of the deep concerns I have.

I applaud you for having this hearing; it is the beginning of this process. I think everyone on this Committee shares a very strong sincerity for our interest in the veterans, and we want to ensure that the independence of the VA is maintained, as well as the survivability of the VA and its viability into the future.

But, I recognize if we take the path of the Health Security Act, it is the beginning of the end of the VA system as we know it, and I associate myself with the comments of Mr Bilirakis. He said it very, very well, and very eloquently, and I applaud the gentleman.

I am concerned, though, about testimony here today after having read the testimony of Dr. Headley who states that, "Clinton's Health Security Act represents the 'best chance' for a strong independent VA health care system capable of providing high-quality services responsive to veterans special needs." I challenge that assumption, and that's the focus that I will have. I applaud the veterans organizations that first gave a strong look to the President's plan and have now said, we are not going to choose that path, we seek the viability and have turned to others of us here on the Veterans Committee to come up with alternatives that really address what's occurring out there in the private sector, whether it's long-term care or eligibility reform. I think that's extremely important.

I think, Mr. Chairman, you are very wise to step forward and say, whether we have the Health Security Act or not, that there are changes out there in the health delivery system from month to month, and that we on this Committee cannot be blind to that and have to accept that responsibility, and I look forward to this debate with you.

Mr. ROWLAND. Thank the gentleman.

The gentleman from California, Mr. Filner.

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman.

I had not planned to say anything, but I was listening with care to my colleagues, the gentleman from Florida and others. I come from a district in San Diego which has a high concentration of veterans. I've been talking to them for at least a year that I've been on this Committee. They see not only strengths, but problems and weaknesses, with the health care system.

In the way I read the President's plan, and I'm not committed to it en toto, it seems that there's an opportunity there for the VA

system to be strengthened. The notion of competition, the notion of quality, and the notion of having to upgrade standards and facilities to compete for health care business, and looking at it as a competitive situation, seems to me to provide us with real opportunities.

I look at it so a glass half filled, instead of half empty. The President has put a plan on the table that forces us to think about how we upgrade the VA system, and these hearings are an example of that. So, I see the President's plan as an opportunity to move forward. I think it provides us with a real challenge to make this system a whole lot better.

I look forward to working with you all to make that happen.

Mr. ROWLAND. Thank you.

The gentlelady from Indiana—no, the gentleman from Washington.

Very well.

Mr. ROWLAND. The witnesses this morning, Dr. Elwood Headley is Acting Deputy Under Secretary for Health, and I'd ask Dr. Headley to introduce those who accompany him. Dr. Headley, will you introduce those persons who accompany you?

STATEMENT OF ELWOOD J. HEADLEY, M.D., ACTING DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY MARY LOU KEENER, GENERAL COUNSEL; CHARLES A. MILBRANDT, ACTING ASSOCIATE CHIEF MEDICAL DIRECTOR FOR RESOURCES; KAREN WALTERS, DEPUTY DIRECTOR FOR LEGISLATION AND POLICY, NATIONAL HEALTH CARE REFORM PROGRAM OFFICE; BOB NEARY, DEPUTY ASSOCIATE CMD FOR CONSTRUCTION MANAGEMENT; AND LINDA KURZ, DIRECTOR, PROJECT COORDINATION AND BUDGET OFFICE

STATEMENT OF ELWOOD J. HEADLEY, M.D.

Dr. HEADLEY. Yes, sir, thank you.

Mr. Chairman, members of the Committee, thank you for the opportunity to tell you about our vision of the new veterans' health care system and the planning now underway to make this vision a reality.

With me today are Ms. Mary Lou Keener, VA General Counsel, Ms. Karen Walters, Director of Legislative and Policy Review of our Health Care Reform Project Office, Mr. Charles Milbrandt, Associate Chief Medical Director for Resource Management, Mr. Bob Neary in Construction Planning, and Ms. Linda Kurz, in Construction Planning.

For the past 13 months, VA staff have been working closely with the Administration to define and preserve an independent health care system for veterans. It's veterans care that we are interested in. For the first time, there would truly be choice open to all veterans and their dependents. The Health Security Act proposed by President Clinton is the only health reform bill we have seen which recognizes the unique health needs of veterans and the importance of preserving and strengthening the VA health system. As the debate in the Congress regarding health care reform continues, we strongly urge that the final legislation contain the provisions re-

garding veterans' health care. They represent the best chance for a strong and independent VA health care system capable of providing high quality services responsive to veterans' special needs.

VA health plans would guarantee the comprehensive benefits packages to all veterans and their families who enroll with VA. The President's proposal would also enable meaningful eligibility reform by allowing VA to provide full comprehensive health care to all veterans and their families who elect a VA health plan. Multiple new funding sources would enhance planning and operations for the VA health system.

The Secretary of Veterans Affairs has recognized the crucial need for VA to address the changes needed to carry out its assigned role under the President's health reform proposal. A Health Care Reform Program Office was established last fall and was charged with developing an implementation plan for VA to make the transition to a competitive health care environment. Almost 200 of the VA's most outstanding managers and health care professionals, as well as representatives of Veterans' Service Organizations, worked intensively throughout the month of January to produce a blueprint for this transformation.

An initial draft of this document was presented to the VA Health Reform Board, composed of the Deputy Secretary and other top VA officials in early March.

Mr. Chairman, because very few individuals in the Department have had an opportunity to review and comment on this report, because it is still in draft form and being changed, and because the Secretary has not yet seen it, we are unable to share the draft document with you at this time. However, I am prepared to discuss the general principles for VA health plan operations which have been proposed.

Mr. Chairman, the work groups identified two key challenges that will be facing VA as a health plan provider. First, all levels of the organization must focus on customer service. We truly must change the corporate culture of the VA to develop, value, and reward behavior that puts veterans and their families first. To achieve a customer focus, we recognize that we must listen to our customers, tailor our programs to meet their needs, treat them with respect and compassion, and serve them with integrity and quality. The draft report recommends several strategies to systematically change the VA corporate culture to focus on customer service.

The other challenge facing VA under health care reform is the establishment of an integrated managed care delivery system. Mr. Chairman, in order for a VA health plan to be an attractive choice, primary care and routine hospital care must be conveniently located for veterans and their families. VA plans will directly provide veterans' care in VA facilities and through a broad provider network which may include affiliated medical schools, community hospitals, community-based professional practice groups and individual practitioners. Enrollees would have their choice of providers within the VA Plan network. VA Health Plans will have to be responsive to the changing needs of enrollees and to the local marketplace.

A key decision for VA plan managers will be "make or buy"—whether to provide the service by VA staff or to contract. The Health Security Act includes liberalized contractual authority for VA which will be necessary in setting up these provider networks. VA managers will need the flexibility and authority to make decisions to buy, lease, or contract for needed equipment and space to meet enrollee needs.

H.R. 3600 would also provide VA with the authority to implement alternative personnel systems for the management of VA health personnel. Our Human Resources work group recognized that the quality of our work force was of paramount importance. Many of the recommendations stemming from Vice President Gore's National Performance Review served as starting points for our discussion.

Organizational, administrative, financial management and information resource decision-making authority would be decentralized to the lowest level that is feasible. VA Plans would receive input from representatives of plan members, Veterans Service Organizations, the academic and research communities, providers and VA facility managers.

We believe the Secretary's decision to establish Veterans Service Areas is an important first step, and that there will be a natural migration of VSAs to Veterans Health Plans.

It has been proposed that each VA Health Plan will develop a detailed business plan, including a financial plan to guide operational decision making at all organizational levels. The business plan would also outline a strategic plan of action for the organization incorporating specific information on marketing, demographics and investment strategies, and be the basis for justifying capital and infrastructure requests. Plans would be dynamic and would be changed periodically to remain responsive to veterans' needs. Our next efforts will focus on developing business planning methodology for all of VHA to be initiated in fiscal year 1995.

H.R. 3600 includes a Health Care Investment Fund that will provide $1 billion in fiscal year 1995, $.6 billion in 1996, and $1.7 billion in Fiscal 1997 to VA. This investment fund is intended to help ensure the VA health care system competes effectively under health care reform.

Mr. Chairman, we are presented with an excellent opportunity to reinvent the VA health system to improve service to the Nation's veterans. Thus, VA is taking a comprehensive look at the way we currently deliver services and is developing a comprehensive plan of action that, we believe, will make VA health plans a competitive and preferred choice for millions of veterans and their families.

Thank you.

Mr. ROWLAND. Thank you very much.

[1The prepared statement of Dr. Headley appears on p. 36.]

Mr. ROWLAND. I would ask that all members limit their questioning to five minutes, and then we'll have a second or third round if we need to, and I will attempt to go from one side of the aisle to the other.

Dr. Headley, I want to commend you for the team work that you all have done here, and I realize that your plans may not be adopted in their entirety by the Department, but if you could spend just

a few minutes with the Secretary highlighting the most important decision, what would you recommend? What would you tell him?

Dr. HEADLEY. I think that our most important decision, and our most important area, is on customer service orientation. This is the thing that if we don't get it right we will cease to exist.

And, customer service orientation, in our view, is a lot more than just being nice to the people who come to our doors. It is a very complex issue that involves culture change, and we have worked with social anthropologists and consultants in change, in cultural change, and we realize that there are personnel initiatives that need to be addressed, that there are workplace issues that must be addressed, that there are clarifications of definitions of the services we offer and how we offer them that must be addressed as part of customer service orientation.

So, my first recommendation to the Secretary would be to continue to explore the changes that are necessary, the personnel, the informational, the workplace changes that are necessary for us to realign ourselves into a truly customer service oriented organization.

My second recommendation to the Secretary would be that we proceed with plans already underway to decentralize responsibility and authority in terms of decision making, so that we have an organization that can more quickly respond to local needs of veterans and local market conditions.

And, we feel that the VSA proposal, which is currently before you, is a first step in that process to allow closer to care decision making.

My third recommendation, and probably last recommendation, would be that the national information systems necessary to running an organization, the complexity and size of VA, which must have local information, as well as national information, in order to function, would be that the informational systems necessary to deliver health care and to do financial and construction and other planning be continued and given highest priority.

In addition, I would recommend that the culture change process, the transition process, be started immediately, which would allow VA to continue working on the initiatives that we have identified and are recommending to the Secretary, recognizing that culture change is not something that occurs by delivering a static plan to an organization, but it is something that the organization itself must engage in full time over a long period of time to have the changes occur that need to occur.

Mr. ROWLAND. Do you have any specific recommendations as to the kind of changes that must be made to achieve the customer service orientation that you have described?

Dr. HEADLEY. Yes. We must, as I said, the customer service orientation is a very complex issue. Just defining what needs to be done in terms of customer service orientation, while important, is not the only part of a change to customer service orientation. A change to customer service orientation basically requires a cultural change in an organization, and a cultural change in an organization is a very complex process.

The specific things that we would recommend are defining standards of customer service orientation, and these are relatively easy

to do, and are done by most large organizations. The second is to educate all employees in the customer service standards, so that they are aware of them. The third is a necessity for having a method of incentives for employees to change their behavior to become truly customer service oriented, and ways to deal with employees who are unable to make these changes. And, finally, a major thing that is necessary for a change in customer service orientation is having the tools and the equipment available to employees to do their jobs, having the information available in a timely manner that is necessary for them to deliver care and make the decisions they have to do.

So, these are some of the specifics that would be required in approaching culture change to customer service orientation.

Mr. ROWLAND. Thank you. Mr. Smith.

Mr. SMITH. Thank you very much, Mr. Chairman, and welcome, Dr. Headley, and your staff, to this very important hearing.

There are a couple of questions I'd like to ask. Dr. Headley, you mentioned in your testimony that the Clinton Health Security Act is the only health reform bill we have seen which recognizes the unique health needs of veterans. Since the Clinton health plan does not specifically provide for spinal cord rehabilitation, blind rehab, comprehensive long-term care and certain prosthetics, could you explain to the Committee what unique health care needs of veterans, especially these veterans, are going to be met by the Clinton plan?

Dr. HEADLEY. Yes. Under the Clinton plan, we would be allowed to function as a system of health care, and we are focusing on veteran health care and veterans' needs.

There are certain programs and certain needs which we feel define VA, and which make VA an important system to continue to preserve, and these, indeed, are the programs that you have outlined, spinal cord injury, blind rehab, rehab, chronic mental illness, long-term care, homeless programs, PTSD, et cetera.

We would continue to provide these, funded by appropriations and nationally directed, so that they would be protected. These would define a core of VA services. They would be provided under current eligibility and as supplemental benefits.

Mr. SMITH. What is the current average length of stay for inpatient admission for post-traumatic stress disorder? And, if you could tell us, what is the length of stay authorized for this diagnosis in the Clinton health plan?

Dr. HEADLEY. I don't believe it is specifically mentioned in the Clinton health plan, but that level of detail is planning that we are engaging in in VA.

Mr. SMITH. Do you see any prospect that there might be a loss of treatment for those suffering from this mental affliction, and is it your testimony as well in those other areas, those core areas that you mentioned, that there will be concrete assurances that there will not be any diminution of those services as well?

Dr. HEADLEY. We will continue to request that we be allowed to provide those services nationally, centrally directed and funded by appropriation.

Mr. SMITH. In speaking about the basic benefits package, and this, I'm sure, will be a very contentious issue in the spring and

into the summer, what is the VA's position on inclusion of abortion on demand as part of that basic benefits package?

Dr. HEADLEY. We have no real position on abortion by demand, other than the fact that we will be providing the comprehensive benefits package, and whatever is defined in the comprehensive benefits package we would be required to provide.

Mr. SMITH. Let me ask you about the prescription drug benefit contained in the Clinton health plan. How does that compare with what is currently provided by the VA?

Dr. HEADLEY. Let me ask Karen. Karen, can you comment on that?

Ms. WALTERS. It's comparable, and the VA, in addition, would continue to furnish medical supplies to veterans under current eligibility.

The Clinton plan expands benefits for durable medical equipment and for prosthetics to veterans who are not currently eligible for those services under current eligibility.

Mr. SMITH. When you say comparable, does that mean it's less than, equal to, greater than? Can we get some detail?

Ms. WALTERS. Prescription drugs are a covered benefit under the comprehensive benefits package, so they are included.

Mr. SMITH. But, for how many days?

Ms. WALTERS. There is no limit on prescription drugs that I'm aware of.

Mr. SMITH. Okay. Anybody else want to comment on that?

Just let me say finally, because my time will be out momentarily, that we would like to take a look at the initial draft of the document, the Health Care Reform Program, or at least information from the working groups that led to this recommendation that's being made to the Secretary. As you know, this is a process and we are not talking about the Manhattan Project. Is there any reason that you can think of why that information cannot be shared in a completely transparent and open way with members of this Committee, both sides of the aisle, so that we can be partners in this effort, rather than waiting for some finished product to come forward?

I mean, there isn't that much time left in the 103rd Congress. The sooner we get the heads up with detail, rather than general principles, the more effective we will be, I think, on both sides of the aisles in responding appropriately to veterans' needs and reform.

Dr. HEADLEY. Right. I think it is our goal to get it to you as quickly as possible. The planning that was done has been done, indeed, there are, perhaps, some aspects of the plan that as we currently have presented it that are not things that we will be looking to present. And, we would rather just get these things taken care of internally.

The plan is not completed, it is still a draft document, it's working papers at this point in time, and we would just like to have a little bit of review. It has had no internal review.

Mr. SMITH. With all due respect, it would be helpful to make us partners. Again, there's nothing secret about this, nor should there be, it ought to be a completely above-board process. And, again, we are cell mates. We care about the veterans as much as you do, and

we want to be a part of it. When do you think we'll get at least some kind of document?

Dr. HEADLEY. I would hope in the very near future, within a month or two.

Mr. SMITH. Within a month?

Dr. HEADLEY. Or two, I would hope. We will get it as quickly as possible.

Mr. ROWLAND. Dr. Kreidler.

OPENING STATEMENT OF HON. MICHAEL KREIDLER

Dr. KREIDLER. Thank you, Mr. Chairman.

You know, veterans in my district have some real concerns, if we don't do anything, what's going to continue to be the case for veterans. It hasn't happened in the last year, it's been happening for years, that they've had a feeling that staffing levels, and wait times, and a number of concerns like that have gotten worse, not better, over time, and that if we do nothing at this point they've got a real problem.

I hear from so many veterans in my district who say that the reason they are at the VA is because they don't have health care anyplace else. And, if they had health insurance someplace else, they wouldn't be at the VA system. It's not necessarily because they don't like the service they are getting there, it's just because that's the only thing that's available to them, and even if it isn't convenient to them because of geography, or other reasons, they are going to the VA system because that's the only thing they've got for them.

You know, with health care costs staggering government right now, the VA system certainly hasn't been immune from that experience, anymore than anyplace else in our society. Any of the government health care programs right now have certainly been falling back as they've increased the budget, but it never stayed up with what was being dictated by the inflationary cost of health care, and the VA system has been a part of that same experience, as I've witnessed it.

And, you know, it's interesting to me that some of the detractors about the reform are the same individuals who would vote for broad cuts in the budget spending that have no shielding at all for the VA system, that would have meant that you would have wound up diminishing the level of care that you have in the VA system that much more and left those same veterans out there that are looking for health care right now to the VA system because they have no other alternatives in many cases, and they look and see what they had there being that much more diminished because you had so much less in the way of resources.

I think the veterans in my district are going to want to know what they are going to have with the VA system if we don't reform health care, as much as they do as about the concerns that they have as health care reform goes forward.

In my state, for example, we are at the cutting edge of what states are doing right now. In fact, our state is effectively saying, federal government, either help us in this process or get out of our way. And, they are at the forefront, they have already passed a

health care reform package that almost mirrors the one that's been put forward by the President.

I'm wondering right now how you feel, how quickly you need to move in order not to be left out of that process, because I can tell you, if the State of Washington, for example, moves forward with its employer mandate, and its alliances that give people purchasing cooperatives that they've been looking for a long time, it's going to be difficult for the VA system if they are left out there trying to compete.

What percentage do you think you are going to wind up losing in a state like Washington of people who access the VA system, and how are you going to be able to play catch up if you are not allowed to get in the front door as health care reform unfolds in a state like Washington?

Dr. HEADLEY. Well, this raises the issue of our participation in states that are undergoing health care reform in advance of national health care reform. In the State of Washington, I believe that we are projecting we could lose 14, 15 percent of the veterans who currently utilize VA, if we are not allowed to participate in some of the changes occurring in the state.

We have a bill that is going forward requesting the ability to participate in up to five states in health care reform in advance of national health care reform, and basically asking for the ability to do some of the things that the states are doing very much like the things that we would see under health care reform, under national health care reform, the ability to engage in contracting in order to set up primary care or continuum of care networks that would look like the private—the care that is available in other health plans.

And, eligibility reform in those states, or the ability once we have an individual enrolled with a VA plan, to deliver the comprehensive benefits package as defined in that state. And, we are very hopeful that our ability to engage in these pilots will quickly be passed.

We do have grave concerns if we don't have this ability.

Dr. KREIDLER. I would put forward that I think that 14 to 15 percent is grossly underestimating that would look elsewhere. This is assuming that you would look at a VA system that continued to be underfunded and wasn't allowed to offer competitive services. I think that the veterans that I see that are accessing that care are traveling very long distances in many cases, because it's the only health care available to them. Could you find it ran considerably deeper than 14 to 15 percent?

Dr. HEADLEY. We've recently done, and I would agree, that figure comes from the eligibility data for participation in health plans in various states, we recently did a national market survey as part of our health care reform effort. We looked at current users, former users and never users of the VA system.

Of the current users, about 25 percent indicated they would leave if they had other options. Of the former users, however, about 67 percent indicated they would use VA again. And, of the never users, interestingly, I believe the number was 27 percent indicated that they would be interested in using VA if they could.

I think this gives us a very important message. Number one, we have problems in our system that we need to fix, and we know

that. Number two, that if we can fix these there is interest on the part of former users and people who have never used VA of using VA.

Mr. ROWLAND. The gentleman's time has expired.

Dr. KREIDLER. Thank you, Mr. Chairman.

Mr. ROWLAND. We'll come back for another round of questioning. Mr. Stump.

Mr. STUMP. Thank you, Mr. Chairman.

Doctor, would VA employees, to be eligible for health care, help the VA change to a more customer-driven system?

Dr. HEADLEY. Would VA employees being allowed to use the system? That is a possibility. I haven't really thought that through. It is a possibility that that would, indeed—currently, we don't intend to offer services to VA employees, but only to veterans and their dependents.

Mr. STUMP. Let me ask Mr. Milbrandt a couple questions. The Phoenix and Prescott, Arizona VA Medical Centers both have Ambulatory Care Deficiencies that are conservatively estimated to be well above 60 percent. Do any of the ambulatory care projects in the VA's investment list address deficiencies greater than 60 percent with annual workloads above Phoenix's 220,000 ambulatory visits per year?

Mr. MILBRANDT. They do address projects that have workload greater than, or space deficiencies greater than 60 percent, but I don't believe that any of them address projects with workload greater than 220,000 out-patient visits.

Mr. STUMP. Other than Florida, are any of these projects in states with the veteran population growing as fast as Arizona?

Mr. MILBRANDT. Other than Florida, no, I don't believe so.

Mr. STUMP. Mr. Milbrandt, I must honestly tell you that I believe a lack of any effort to account for what is called "stress demand" in construction planning, especially in the Sunbelt, renders the VA's methodology and conclusions about priorities invalid.

When VA applies historical workloads on the future population projections to an estimated future demand, without accounting for the length of the line at the front door waiting to get into that facility, in the Sunbelt, you simply perpetuate growing deficiencies. Why does VA continue denying the need to measure the in line at the front door when planning for prioritizing future construction?

Mr. MILBRANDT. Well, the VA does use the prioritization methodology, and as a part of the prioritization methodology there is a forecast for veteran growth and need. And, what that translates to is a higher priority score when you run the formula.

Mr. STUMP. But, that priority doesn't take into consideration those that are not able to get into those facilities, does it?

Mr. MILBRANDT. No, it wouldn't.

Mr. STUMP. Well, the fact that we are so high on the list as far as the people that can't get in there, shouldn't that be taken into consideration?

Mr. MILBRANDT. Yes. VA recognizes the need for a project at the Phoenix facility.

As you know, when we established the current list for ambulatory care projects, we asked medical centers in this last round to refocus on longstanding current deficiencies in ambulatory care.

Phoenix was one of those projects that we looked at. It was a very large project. We asked the medical center to rescope their project and submit it.

It wasn't rescoped timely enough to be included in the 1995 submission.

Mr. STUMP. It was not?

Mr. MILBRANDT. It was not.

And, even if we receive funds for 1995, the project really isn't ready to be included in it. It wasn't really ready to be included in the 1995 budget.

Mr. STUMP. Thank you.

Let me commend you, by the way, for your responsiveness to my staff, and working with our Committee staff here. We appreciate it very much and look forward to working with you in the future.

Mr. MILBRANDT. Thank you.

Mr. STUMP. Thank you, Mr. Chairman.

Mr. ROWLAND. Thank you. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Doctor and other members of the panel, I believe Mr. Filner may have said it, and I've said it many times, that the fact that the President has brought a national health care plan out and put it on the table that there's an awful lot of good byproducts coming from that. And, you know, one of them could be this—you talked about the two challenges, one of them being the focusing on customer service. Doctor, well, that's fine, and if the Clinton health care plan were to be the plan, or if it were to be another vehicle, it forces us to meet that challenge. But, it seems to me that's a challenge we've always had. I mean, why haven't we always focused on customer care? We know quite often that many of our employees in our veterans hospitals almost look at a veteran as maybe a welfare type of a thing, and make them feel very degraded.

So, I just sort of wonder why it's taken so long to focus on these types of issue? I'm pleased that it's taken something like this to make us focus on what I think should be routine things. Do you have any comment on that?

Dr. HEADLEY. Yes. I think that the answer is unfortunately competition. I think that as long as VA had, if you will, a monopoly on veterans care, there was a tendency for it to become somewhat bureaucratic in delivery this care.

That's not to say that there have not been very significant efforts through the years to improve customer service orientation in VA; there have been. But, it seems that, perhaps, the drive was not strong enough to fully carry the day, and we are aware that we have difficulties with customer service orientation. And, we view this as our number one priority and the number one thing that must be corrected, because under a universal access methodology of health care delivery, if we can't compete, if we can't deliver services in a timely manner, in a way that people want, they will go elsewhere.

Mr. BILIRAKIS. Yes. Well, I would hope that—I know that you've given many, many good years of service to our veterans over the years, and I believe soon you are going to become the administrator of a hospital?

Dr. HEADLEY. Chief of Staff at Boston.

Mr. BILIRAKIS. Chief of Staff of a hospital.

Dr. HEADLEY. Right.

Mr. BILIRAKIS. So, I would hope regardless of what happens with universal coverage, the Clinton plan, or whatever the plan is, you still consider that as a top challenge in the new hospital you are planning to go to. I'd like to feel that will be the case.

Doctor, obviously, this competition angle is something that concerns me and concerns all of us, and I was very pleased to see Mr. Kreidler comment on that too.

One of the things that really concerns me about the plan is the VA's uniqueness. I don't have to tell you how much uniqueness there is in the VA medical care system, care that much of the private sector is just not trained or equipped to be able to furnish. And, we are going to have these alliances out there, and I don't know what's going to happen to the alliances, whether they will still remain in the picture or whether their roles will change. But they are going to basically determine the benefits packages for the Veterans Administration.

And, you know, it worries me, it scares me, are these people going to be qualified to determine how much emphasis should be placed on SCI, for instance, and prosthetics, and things of this nature? That's a great big concern on my part.

We've got to look at the real world here. I realize your job, and the job of the people on the panel, is to carry the ball for the Administration. That's part of your job. But, you also are a doctor. You've also been in this system for many, many years. I know you are concerned about all of these things. Any comments regarding that?

Dr. HEADLEY. Well, we, indeed, are focusing on veterans' health care, and that is what we have been focusing on. We are focusing on what it is that makes our system unique.

Mr. BILIRAKIS. Well, but, sir, forgive me, I'm talking about the future, and I'm talking about a board up there of people who probably would not have a Doctor Headley on that board determining the benefit package for the veterans.

Dr. HEADLEY. You know, I really can't speak to that hypothetical case. As I mentioned earlier, we are hoping—we are planning to include in our supplemental benefits the very programs that you have mentioned. These would continue as benefits for veterans, and I think would not be controlled by a national health board.

Mr. BILIRAKIS. Well, you think, but there's a concern. I know the PVA last week came in here and testified, and they were very much concerned about the lack of prosthetics and things of that nature in the President's plan.

And, we're talking about adding it in as supplementary benefits, and we think the National Board is going to follow through in that regard. Right now we know that we are not perfect, and we know we are underfunded. But we also know that SCI and prosthetics are not included.

So, we don't want to be obstructionists up here, but we're concerned about these things.

Mr. ROWLAND. The gentleman's time is up.

Dr. HEADLEY. I would agree that these are programs that we need in VA to give our highest priority, and we need to ensure that they continue.

Mr. ROWLAND. The gentleman's time has expired. We'll come back for another round. Mr. Buyer.

Mr. BUYER. Thank you, Mr. Chairman.

People like to use the phrase "national health care reform." That's the big warm and fuzzy, and it sounds good because it shows you've got compassion and sincerity and nobody wants to feel as though they don't have that. We ought to call President Clinton's plan what it is, though, and it's called government control of health care, but nobody wants to say that. If we call it national health care reform, it sounds good.

Mr. Bilirakis, I'm going to pick up where you left off, because you had a very good line of questioning. I think we can use Canada as a very, very good example. If I may, Mr. Chairman, in 1944 the Canadian Department of Veterans Affairs, DVA, was created. It assumed the responsibilities of the Department of Pensions and National Health, including veterans' health care, welfare and other benefits.

Veteran patient workload peaked in 1947. By 1948, the DVA began to fill empty beds by expanding their treatment program and admitting additional veterans and other groups for which the government had responsibility.

In 1953, an increase in chronic diseases, elective surgery and decrease in acute treatment levels resulted in difficulties in recruiting and retaining medical staff.

In order to counter these trends, the DVA decided to treat any veteran who was willing to pay for treatment. In making this decision, the DVA argued that it could acquire the case mix necessary to attract doctors, support staff necessary to maintain that system.

In 1957, the Canadian Hospital Insurance and Diagnostic Service Act was passed. This Act initiated the concept of universal hospital and diagnostic coverage for all Canadians. This program significantly affected the workload of the DVA, since given a choice of hospitals many veterans opted for alternatives to the DVA system.

By the early 1960s, it became apparent that the need to care for wounded veterans had significantly decreased. With the diminishing need came the increased problem of recruiting new health care professionals to practice "veterans medicine." At the same time, the cost of operating DVA facilities was increasing. This caused a fundamental change in the way the DVA delivered health care.

In 1960, the Royal Commission of Government Organization recommended that the government build no additional veterans hospitals, and that the treatment of veterans be transferred to community hospitals. Veterans with major, chronic and domiciliary pensionable disabilities would remain federal responsibilities, while other veterans would transfer to community hospitals. DVA hospitals, when empty, would then be sold and converted to community hospitals.

Even though the new system gave veterans priority access to hospital beds, Canadian veterans believed the government had abandoned its responsibility for those who had been wounded at

time of war, and at the very least it abolished a separate health care system for veterans.

In 1966, the Medical Care Act was passed, giving Canadians, including veterans, universal health care coverage. Since all veterans were covered, they began seeking care outside the DVA system. The DVA's role was reduced to managing departmental programs, specifically designed activities to meet specialized needs of veterans, very similar to the ones that you, perhaps, just spoke about as core needs of veterans in America.

By 1991, the DVA had transferred 13 institutions to provinces and communities, and today only administer three long-term care facilities nationwide.

That scenario is what we do not want to have happen in America. So long as I remain on this Committee, and a Member of Congress, I will not allow the VA system to fade away.

So, if we begin down the path of universal coverage that is why many of us have that concern. Whether you get in the front door, you come in the back door, or you come in late, it's still that path.

Now, here is where Mr. Bilirakis was asking the questions about the National Health Care Board, because we are talking about independence. The VA will come under the jurisdiction of the seven member National Health Care Board, will they not?

Dr. HEADLEY. Yes.

Mr. BUYER. The basic benefits package, the utilization rates, and how diseases are treated also comes under the jurisdiction of the National Health Care Board, does it not?

Dr. HEADLEY. We would be under the National Health Board, it's my understanding, unless that contradicted already existing federal law. We have been promised that current eligibility would be preserved, and we share the concerns that you addressed in your reprise of the Canadian system's unfortunate demise of veterans' health care.

And, we have held this story in front of us throughout our planning efforts, and we agree with you that it has been our goal to see that this doesn't happen to VA. We think that VA must be preserved in order to continue to focus on those special aspects of care that have never been done well by the private sector, for whatever reason.

Mr. BUYER. We were talking about the basic benefits package. In the Health Security Act it says, "Not later than one year after the date of the enactment of this Act, the National Health Board shall establish and oversee a performance-based program of quality management and improvement designed to enhance quality, appropriateness, effectiveness, health care service to access such services." So, they are going to have a 7 Member board, then they are going to have another 15 panel board appointed by the President that will set out quality assurance and those types of issues, as well as set utilization guidelines, not only in the private sector for the basic benefits package, for which a doctor must follow or doesn't get paid, but also in the VA. If that's the control we are having in the private sector, that will also be in the VA, will it not?

Dr. HEADLEY. We will be responsive, yes.

Mr. ROWLAND. We'll come back. The gentleman's time has expired. We'll come back.

Mr. BUYER. All right. The answer was yes?

Dr. HEADLEY. Yes.

Mr. BUYER. Thank you.

Mr. ROWLAND. You mentioned, in response to Dr. Kreidler just a few moments ago, the National Market Survey. Would you submit that for the record, so that we can have that?

(See p. 40.)

Dr. HEADLEY. Certainly.

Mr. ROWLAND. Let me point out some of the problems that I have with the President's plan as well, and how it may affect the VA.

I had the opportunity yesterday to meet with, speak to, and listen to people from the Academic Health Centers around the country; people who are presidents of medical schools, and several of those were presidents of medical schools that are affiliated with the VA, about 101 or 102 of those.

They expressed concern about loss of patients under the President's plan. They talked about the loss of funds as well under the President's plan. A lot of the funds come from pharmaceutical companies for research, and I'm getting at this from the standpoint of how those hospitals that are affiliated may be affected.

The president of one medical school that was affiliated with a hospital talked about having to work in cooperation with the veterans hospital and not competitive. We talk about being competitive, how they are going to have to work with the hospitals.

So, I'm really concerned that there would be a decrease in patient load, a decrease—based on what they said—a decrease in patient load, decrease in funds, and how that may adversely affect those affiliated hospitals.

I guess in looking at what you are doing in restructuring that whatever you do must be able to fit into whatever actually takes place insofar as health care reform is concerned. Do you have any fears relative to what I have just mentioned?

Dr. HEADLEY. We certainly share your concerns, but we view this as an opportunity for greater collaborative functioning between our affiliated hospital medical centers and our VA medical centers.

We, as you know, have 120 VA medical centers that are affiliated with 102 of the 126 medical schools in this country. We included members from our affiliated institutions in our planning efforts, and they were a part of our planning efforts.

We look at this as an opportunity to collaborate with them in developing mutually beneficial programs and in changing the nature of health education to produce more generalists as we go forward.

I think that we haven't gotten as far with the planning with our affiliates as we need to, but there are several very innovative affiliation proposals that are coming up around the system.

Denver, for instance, has developed a proposal assuming health care reform and assuming VA's greater flexibility in forming contractual relationships with other organizations. The University Colorado Medical School, and their University Hospital, and the VA medical center in Denver have a proposal that would allow them to integrate some of their diagnostic capabilities, their radiology, their laboratories, that would allow them to integrate some of their support services, such as their food services, and that would have them going out with a unified VA university health plan that

would have a primary care network around the state, and would refer patients back to the university and to the VA medical center.

I think that we will see a lot more proposals of this nature, very collaborative proposals from our university affiliates and our medical centers as we get into health care reform more fully.

Mr. ROWLAND. You mentioned just a little bit ago what you were proposing, which is very similar to our legislation, for some projects in states, to see how well they would work.

Dr. HEADLEY. Right.

Mr. ROWLAND. Can you tell me the status of that proposal that you have right now, and do you have any kind of time line for action?

Dr. HEADLEY. Yes. Ms. Keener, could you comment on the status of that proposal at this point in time? Has it come, the states proposal?

Ms. KEENER. We have a bill that has gone to the Speaker that we anticipate will be introduced. We understand there are many similarities in our bill with the bill that has been introduced here regarding state projects, and we're hoping that we'll be able to get the authority we need to move ahead in these states as quickly as possible.

Mr. ROWLAND. Who would introduce that bill?

Ms. KEENER. At this time, I don't know Mr. Chairman.

Mr. ROWLAND. Okay, thank you. Mr. Smith.

Mr. SMITH. Thank you, Mr. Chairman.

Dr. Headley, if the VA continues to care for its current population of veterans, how many more primary care providers will the VA need to hire in order to shift to primary care?

And, before you answer, I met with approximately two dozen physicians in my district, and some from outside the district. Some were specialists, some were primary care providers, and the issue of quality and the loss of quality envisioned by, in their view, the Clinton plan as it relates to the number of specialists, cutting in half the number of specialists, is a real concern. They felt that this would lead to a real loss of quality, because, you know, the primary care provider goes so far, and then he says it's above my pay grade, or I haven't specialized in that, then for the good of my patient he or she is being referred to this specialist. And, they see that that trend line could be a disaster for quality of health care in this nation, and they are unanimous in their view on this. And, these are the front-line people who are actually providing care.

I am so totally concerned, as are my colleagues on both sides, about those specialized core services that are provided and that if we rely on appropriations in looking to the future, I think Warren Rudman and Paul Tsongas are right, we are looking at a sink hole in terms of available discretionary funding into the future and funding in general. You know, there may be a blip right now in terms of the deficit seemingly being mitigated, but it very quickly spirals upwards and any major catastrophe, floods or whatever, could quickly put even the projections that are somewhat rosy for 1995 at peril.

So, we would be spending money we don't have, and.in the future Congress can't be bound for sure by what we do now, you know, under the guise of crisis they could very quickly say that this blind

rehab, this spinal cord injury money is no longer available to the extent that it could have been had we changed the plan now.

If you could tell the Committee how many primary care physicians, say, over the next five years, will have to be hired, and how that comports with the FTE reductions of 25,000 envisioned by Mr. Clinton over five years? You know, we are saying we're probably going to need more to service this expanding VA network, while at the same time we are cutting staff.

And what is the price tag of those core services right now for spinal cord injury, for blind rehab, those that are just absolutely connected to the service-connected disabled veteran? Of the medical care budget for fiscal year 1995, for example, what's the cost and percentage?

Dr. HEADLEY. Okay. Taking your first question first, the number of primary care providers that we would need to hire, and the presumption that we would be doing away with our tertiary care capabilities, and I think that is a misperception.

We currently exist mainly as a tertiary care referral system. We have grown up that way, and we have concentrated on inpatient, more complex care. We still need that.

We do not propose to do away with that. We, perhaps, in some areas, have more tertiary care capability than we truly need, and this will be adjusted on the basis of demand and quality.

What we need the ability to do, though, is to plan for the primary care needs of the veterans for whom we care. The number of primary care providers that we need to hire may be none. We may, indeed, find it more cost effective and of better quality to contract for primary care provision, and these should be market-driven decisions made locally by health plans, by VA health plans, as they develop their business plans, they look at their local market, and they see which things would be better to buy and which things would be better to own.

And, at this point in time, it's impossible to say how many primary care providers we would need to hire. That's quite variable.

In terms of the special services that we provide for veterans and the percentage of our current budget that that encompasses, I don't have that figure at the top of my head, and I will have to submit that in writing, if you would permit.

Mr. SMITH. That would be very helpful, because then we would know what the price tag of those core benefits entails as we move through this, because I remain concerned that the pressures will be to crowd out those core services that are absolutely essential, and it will be done incrementally not overnight.

(Subsequently, the Department of Veterans Affairs provided the following information:)

The fiscal year 1995 budget provides workload and cost estimates for categories of care and is not patient specific. The current VA accounting systems accumulate costs by facility with distributions at the macro-level as to the type of care provided (such as hospital bed section, outpatient and long-term care).

The typical veteran patient receiving VA care is receiving both those services which would be covered under a Basic Benefit package as well as services which would be over and above such package. At this time, we are unable to track the costs of a specific patient and, therefore, cannot accurately determine which of the costs a veteran incurs fits into a basic benefit package. VHA is currently developing a patient specific costing system, Decision Support System (DSS). This system, working with VHA's DHCP system, will provide the ability to determine and track

the costs associated with each episode of care for each patient. This data is expected to allow the VA to budget and plan for resources broken into the Basic Benefit package under health care reform as well as those additional services provided to service-connected and other entitled veteran patients.

Mr. ROWLAND. The gentleman's time has expired. We'll come back again. Mr. Stump.

Mr. STUMP. Thank you, Mr. Chairman.

Doctor, I'd like to follow up on what Mr. Bilirakis was saying a while ago. I believe you said that VA hospitals can compete. It's a well-known fact that we're over a billion dollars behind in purchasing new equipment, and with the deficiencies we have in many of our hospitals, at least throughout the Sunbelt, how in the world can we compete with the modern specialty hospitals under those conditions?

Dr. HEADLEY. I don't believe I said that we could compete as we are now. I said that we are asking for the ability to be able to position ourselves to compete, to have some of the restrictions on our contracting abilities released, to have our eligibility simplified, to have the infusion of funds from the investment fund made available so that we can begin to address some of our deficiencies that will allow us to compete. We also have to have a culture change that will allow us to develop a customer service orientation that will allow us to compete.

We have a tremendous amount of work ahead of us if we are to compete. I don't mean to convey the impression that I think we can compete as we exist at this moment in time.

Mr. STUMP. Well, competition implies a winner and a loser. What happens if we lose? Are we going to go the way that Canada, and Australia, and New Zealand, West Germany, Finland have gone then?

Dr. HEADLEY. I think that we use competition as we speak in health care reform to mean several things. I do think that it can mean a winner and a loser. When we speak of competition, what we generally mean is to develop our system and to change our orientation of care delivery to those that would make us attractive to veterans who want to use our services so that they would select our services and would make us responsive to the needs as they indicate them.

Mr. STUMP. To your knowledge, has a VA system survived in any of the countries that have adopted a so-called "nationwide health reform" of some sort?

Dr. HEADLEY. I'm not aware.

Mr. STUMP. Thank you, Mr. Chairman.

Mr. SMITH. Will the gentleman yield?

Mr. STUMP. Yes, certainly.

Mr. SMITH. I think that's an appropriate question and, perhaps, a survey of other nations would be more than helpful. I mean, if this has been tried before, we might learn from their mistakes, as well as their successes.

Mr. ROWLAND. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Doctor, I am a veteran, four years active duty in the early 1950s, and I always consider myself a grassroots guy, and still, before I came to Congress and immediately asked to be on this Committee, which makes this my 12th year, I had no idea that veterans so

very zealously protected and wanted to protect their separate health care system.

And, by gosh, I've learned a lot of things in 12 years up here, but that's one right at the top of the list.

Now, the Clinton plan is the only one, I guess, that refers to the veterans, and brings veterans into it. None of the other plans do. And, I just wonder, you know, if we're using veterans' health care as a political football. We look like we are saying that we are concerned about it surviving, and it makes us look like we're against the plan, we are obstructionists. Many people on the other side of the aisle, not all, but many people on the other side of the aisle say, well so, they look at the glass as being half full rather than half empty. Mr. Stump asked you about this competition idea, and what if we lose and that sort of thing.

So, it's something that I hope you will carry forward. Were you involved personally with this 500 member, or whatever the total was, task force that was gathered together by the First Lady to determine the National Health Care Plan?

Dr. HEADLEY. Yes, I was.

Mr. BILIRAKIS. You were personally involved?

Dr. HEADLEY. Yes.

Mr. BILIRAKIS. Well, I'm glad to hear that. I would feel a lot better if I knew that someone like you would be on this National Health Board to help determine what the eligibility would be, and what the basic benefits package would be.

But, last year we were told that VA would begin to shift resources over to ambulatory care so that the Department could become competitive in national health reform. However, the Clinton budget reduces major medical construction by 45 percent, and of the few medical projects that were funded, as I understand it, three add to VA's inpatient bed capacity, the remaining two add research projects at two sites that were never even on VA's five year facility development plan. I wouldn't be too surprised to find out that those two sites happen to be very political and in somebody important's district.

The President's budget includes eight ambulatory care projects, but basically says, those will take place only if the Clinton Health Security Act passes.

Now, if these eight ambulatory care projects are necessary to furnish adequate health care to veterans, why should they be tied in to the Clinton Health Security Act? Why should they be tied to that, or subject to that?

So, I guess I'm not really asking you for an answer there, but to me it's an illustration of how veterans' health care has become a part of a political football, we are kicking it back and forth here, and I wonder if that isn't the reason why none of the other plans have approached veterans. It wasn't the case that we didn't care about veterans, it was a case of wanting the veterans' health plan to be completely separate, and so why mention it, we just don't want it to be a part of national health care. We want it to remain like it is, we want this Committee to try to improve it. We want this Committee to try to continue to fund it and maybe do a better job of funding it, but we didn't want it to be a political football.

Dr. HEADLEY. I can just comment that we certainly have not been viewing veterans' health care as a political football. I mean, we have been technically planning for veterans' health care, given the arena that we are presented with, and doing our best to come up with a viable plan.

Our concern for not having veterans' health care mentioned in a health plan is that it will be neglected, people will be given other choices. We will not have the ability to make needed changes in service delivery to veterans, so that it will be an appealing choice if they have other choices, and that we will suffer the same fate as the Canadian veteran system. That is our concern.

Mr. BILIRAKIS. Well, I can see where there is some merit to that concern.

Mr. Chairman, I understand that the mark-up on this portion of the Clinton plan is going to take place late in April, the staff knows better than I. I don't know how in the world we can hold a mark-up unless we've received from the VA this plan that apparently they promised within a month or two.

I mean, it seems to me it stands to reason that we've got to take a look at that plan and study it before we can hold a mark-up. Otherwise, we're going into it bass ackwards, if I've said that correctly, I'm not sure.

Mr. ROWLAND. I guess there's a couple of problems there, and you mentioned one of them, and the other one is we don't know what plan there will be.

Mr. BILIRAKIS. Right, and there's a market study, too, that's been talked about here, a couple things that Mr. Smith has talked about. I don't know how we can do it without knowing more information. Doctor, you say a month or two, I'm not sure exactly where that stands, but we ought to have that before we go into mark-up.

Dr. HEADLEY. I will relay this concern, certainly.

Mr. ROWLAND. Thank you.

I think that what we will do is we'll recess briefly, and Mr. Bishop, when he comes back, will take the chair, so that we can proceed. He should be back within the next four or five minutes. Just hold your positions.

[Recess.]

Mr. BUYER. Thank you, Mr. Chairman.

In the testimony before this Committee on March 10th, Secretary Brown stated that the Huntington, West Virginia, Research Addition project, which was included in the Administration's fiscal year 1995 budget request, was ranked 298th out of 380 VA construction priorities. The Portland Oregon Research Addition Project, also included in the Fiscal 1995 budget request was not even ranked, as reported by the Secretary.

However, in the latest list provided to this Committee, both projects have been scored and are now included in the VA's top 100 major construction projects. So, it is interesting to note that the Secretary testified one way on the 10th, then the VA Committee is provided documentation that now says it's in the top 100, and the information that was supplied to this Committee had a date on it of March 1, 1994, nine days prior to the Secretary's testimony.

So, please provide to this Committee, with the appropriate back-up documentation, that shows how these projects were scored and

why they moved so far up the list of priorities for construction, or if you have the answer today I welcome that.

Mr. MILBRANDT. Yes, Mr. Buyer. They were included on the list because we were asked to provide a list of the top 100 projects, which included those in the 1995 budget.

Mr. BUYER. So, the Secretary's testimony was in error?

Mr. MILBRANDT. No, no, we were asked to include, by this Committee, the 1995 projects on to the top 100 list, we were asked to include those. And so, we did.

Mr. BUYER. All right. This Committee made a request——

Mr. MILBRANDT. That's correct.

Mr. BUYER (continuing). To take those two projects, one of which was——

Mr. MILBRANDT. And, incorporate them——

Mr. BUYER (continuing). Not even ranked, and one that was 280 out of 380.

Mr. MILBRANDT. (continuing). And to and to score them and to integrate them into the list, and that's why they——

Mr. BUYER. Who from this Committee?

Mr. MILBRANDT. Minority Staff.

Mr. BUYER. Minority Staff.

Mr. MILBRANDT. Yes.

Mr. BUYER. Who from Minority Staff?

Mr. MILBRANDT. I think Carl Commenator, I believe.

Mr. NEARY. The intention was not to suggest that the priority increased, but to show on the list of 100 where the projects that are in the 1995 budget would fall in competition to the others. I don't think there was any suggestion by the staff that these should be increased in priority to fit within that list.

Mr. BUYER. Here is a little curiosity factor I have here. If we are going to even go through the bother of ranking and giving priority to projects, why do we end up picking one that's 298th and one that isn't even on the list? How did that happen?

Mr. MILBRANDT. I think the Secretary responded to that during the hearings as, that those projects were included in the 1995 budget at the request of the Administration.

Mr. BUYER. Politics.

Mr. MILBRANDT. They were included as——

Mr. BUYER. That's what it is.

Mr. MILBRANDT (continuing). At the request of the Administration.

Mr. BUYER. Included at the request of the Administration. To me, I'm just a good old boy. This is my first time up here in the Congress, first time in political office, and that's called politics, at least that's what we call it back in the rural areas.

See, if there's an example like this that shows the VA cannot insulate itself from the pressures of the Administration, then what is going to happen to the VA health care system?

If I can expand beyond where we left off when my time ran out, and if Mr. Bilirakis went over this please excuse my redundancy. We were talking at that time about the fact that the VA is going to be under a National Health Board, of which there will be the National Quality Management Council, 15 members are in that. As I understand and I'm going by the Health Security Act, we've got

these alliances out there now all across the country, and under these alliances comes the VA benefit plan. In order for them to monitor what's happening out there in all these alliances all across the country there has to be a reporting mechanism.

So, help me in my understanding, the VA, within those alliances, will be reporting to the heath alliance, will they not, information, census data, how many patients are being seen for, what they are being seen for, is that correct?

Dr. HEADLEY. I have a somewhat different understanding than that being put forward. It is my understanding that the National Health Board will attempt to set, or will be engaged in the process of setting national standards in various areas. Now, these standards already exist. They vary by state. They vary by department, and the National Health Board would be an attempt to develop national standards.

They would develop these standards in several important areas, and one you've mentioned is quality assurance standards.

The National Board, however, would relate to the alliances and would provide guidance to the alliances.

The VA would offer itself as a health plan at the alliance, as other health plans. This would be very much like the FEHBP, or the Federal Employees Health Benefits Plan, from which most of us select our insurance, and plans give information to the FEHBP, and would give information to the alliance, regarding their cost, their quality, and their patient satisfaction.

Thus information would be made available to people desiring to select a plan, much as we get a brochure annually from FEHBP, that allows us to make informed judgment as to which plan we would like to select, based on the quality and the offerings of those plans.

That is my understanding of VA's involvement with the alliances, and, furthermore, VA is to be protected, if you will, in that while we will be responsive to the alliances, we will not be held to anything that is against currently existing federal law.

Mr. ROWLAND. We'll come back to the gentleman. Mr. Bishop.

Mr. BISHOP. Thank you, Mr. Chairman.

Dr. Headley, is it not critical, both to the development of a sound construction program, and to preparation for national health reform, that our medical center missions be reviewed and realigned where appropriate, and can we expect that to happen in the near term, absent a congressional mandate?

Dr. HEADLEY. Absolutely. I think that one of the most important things that we are learning in the health care reform process is that we must look at what we need to provide the continuum of care for enrollees in a VA plan, and how we would deliver this continuum of care in a network of providers.

And, I think that in the process of doing this, we will be looking at missions of VA facilities, and seeing where they fit in the continuum of providing health care.

Mr. BISHOP. Let me follow up on that. As a part of that process, have you, or will you, consider, or is it being considered, the possible joint use of DoD facilities with the VA, so that where there are, for example, military hospitals, but no VA inpatient facilities,

that you could possibly join that as a part of your construction program along with DoD?

Dr. HEADLEY. Well, let me just make an opening comment on that and then I'm going to ask Mr. Milbrandt if he would elaborate on this. I would just like to say that VA is, indeed, interested in many aspects of sharing an involvement with DoD, and we are, and will be, actively pursuing ways to engage in sharing in mutually beneficial projects with DoD.

Chuck, would you like to comment?

Mr. MILBRANDT. Yes. The 1995 budget includes two projects that are joint VA/DoD ventures. One is at the facility with the Air Force at Travis, and the other one is in Brevard, Brevard County, and that's part of the 1995 budget.

We also have active facilities underway for sharing in Anchorage, the Las Vegas project is a shared facility with the military, as well as, of course, Albuquerque.

Mr. BISHOP. Okay. I'm particularly interested in Georgia, particularly, the southwest portion near Fort Benning, which serves veterans from both east Alabama, and west Georgia, and south Georgia. I would hope that you could possibly consider some joint use of the Martin Army Community Hospital facility at Fort Benning, along with DoD, which is, of course, in need of upgrading, but it certainly would facilitate both the DoD mission, as well as the VA mission, and service a lot of veterans who are in that area who now have to go great distances to receive service.

Mr. MILBRANDT. Yes. We have not examined, in this last round, a sharing of facilities at Fort Benning. However, as a part of this next round of solicitation and looking for ideas for the investment fund, we encourage facilities to examine closed Reserve unit buildings and also to look at military bases for potential joint use.

Mr. BISHOP. How can we facilitate that to expedite it, the consideration of it?

Mr. MILBRANDT. Well, we'll make a note of it and talk to the staff. The closest medical center is really the facility that would need to initiate a proposal for the joint venture. Of course, the military needs to agree that they have excess capacity and space.

Mr. BISHOP. I don't know that they have excess capacity and space, but there's a great need and, of course, we've got a two state problem there. The nearest facility, I think, is in Tuskeegee, which is an old facility, and which is not the most convenient for many of the veterans in Georgia.

Mr. MILBRANDT. We'll be glad to take a look at it.

(Subsequently, the Department of Veterans Affairs provided the following information:)

Management at the Tuskegee VA Medical Center has long sought a meaningful relationship with the Ft. Benning installation and its MEDDAC at Martin Army Community Hospital. About seven years ago the Medical Center Director of the Tuskegee VA Medical Center (TVAMC) met with the then commander of the Ft. Benning MEDDAC, Colonel John C. Richards, to discuss the possibility of bringing VA services to the Columbus area, either by a joint use of current space or the creation of a VA clinic on Ft. Benning property. No interest was shown in supporting this initiative. Since that time the TVAMC has created and supported a Community Service Program based in Columbus, GA, and over the past six years has augmented this program to the status near that of a clinic with a limited medical service potential. The Director, TVAMC meets periodically with the Commander, Martin

Army Community Hospital to explore increased sharing as a means of improving service for Columbus area veterans.

Mr. BISHOP. Thank you.

Mr. ROWLAND. Thank you.

I have one additional question I wish to ask. I'm sure members will have questions they would want to submit as well.

Dr. Headley, the Secretary proposed reorganization of VA regional offices into veteran service areas, VSAs, that cross state lines. There appeared to be a question of organizational entity for paving the way to health care reform, which appears likely to be state based. How is that going to work?

Dr. HEADLEY. Yes. I think that VSAs will be a logical first step in beginning the process of having a more decentralized, more locally responsive, more flexible organization.

I think that within the VSAs, there will be networks of hospitals, and, indeed, some of the networks and the VSAs do cross state lines, but they cross state lines for a reason. They cross state lines because they are geographically related, and I think that even though much of health care reform as proposed will exist by state, there are provisions that have been developed, and there will have to be provisions for dealing with populations that are going to have to cross state lines.

I don't really believe that this is going to be a problem, but it is one of the things that we are looking at very carefully, and that we may have to change and evolve further as we see specifically what plays out in terms of health care reform.

Mr. ROWLAND. Would one VSA, say, belong—one part of a state belong to one VSA and another part of that same state belong to another VSA, would states be split?

Dr. HEADLEY. There are some cases in which VA medical centers and their catchment areas within a state belong to geographically different VSAs.

Mr. ROWLAND. So, the states may be split.

Dr. HEADLEY. Yes, they may be split.

Mr. ROWLAND. Okay, thank you. Mr. Smith.

Mr. SMITH. Thank you very much, Mr. Chairman.

Dr. Headley, it seems to me as if the VA has put all of its eggs in one basket, as a matter of fact, if I'm not mistaken the working groups only considered the Clinton suggestion, the health care reform suggestion, and no others.

And, in looking at assumptions in the VA budget for next year and out years, the program level for construction, for example, is cut by 70 percent in the budget. The estimate for 1994 is $475 million, then drops down to $141 million. What happens if health reform does not pass? Do you have other scenarios, or other numbers that you are looking at, if health care reform, as we all are looking at it now, does not become a reality? I would hate to see the veterans that much further behind the eight ball and that much further off as to where they might have been had we just also assumed a non-passage. I think specifically looking at the health care or the construction budget, where you factored in, in your figures, a substantial decline in construction, and the need as we know is growing, not diminishing. I realize contracting out has its place, but we are talking about the assumption being that this thing does not

pass, or something other than the health care plan envisioned by the President passes.

Dr. HEADLEY. I would like to sort of split your question into two parts, if I may, and ask Mr. Milbrandt if he would comment on a construction part of it.

In terms of putting all eggs in one basket and planning, this I might hasten to mention was the only bill that mentioned VA or veteran health care. We have been involved with planning for veteran health care, and we have been planning toward the bill that mentions VA and that considers VA as a part.

I think that much of the planning we have done is valid planning for VA health care, and, you know, we hope that however H.R. 3600 passes VA concerns will continue to be addressed.

Mr. SMITH. Let me just ask an additional question before you yield. Would you have had a different budget for construction if the Clinton plan was not a proposal on the table? And, have you looked at any other plans, for example, or tasked those working groups to look at how the President's plan and VA interface? That's all fine, well and good, but there are other plans, there's eligibility reform possibilities that hopefully we will move forward on.

It seems to me there ought to be a whole different set of scenarios. So if this happens then this is what we are ready for. It seems to me, and I may be mistaken, that the construction budget is predicated on something very close, if not identical, to the Clinton plan passing. And, again, I think our veterans will be that much further injured if the assumption turns out to be faulty and Congress has its way and goes in a different direction.

Dr. HEADLEY. Right.

Mr. SMITH. I mean, do you reconvene those working groups then? Meanwhile, fiscal year 1995 is that much further prejudiced. I know you wanted to respond.

Dr. HEADLEY. The development of the construction budget was not really something that occurred as part of our planning for veteran health care.

I would ask Mr. Milbrandt if he would comment on that.

Mr. MILBRANDT. In developing the projects, and in placing some projects in the appropriations process, and some in the investment fund, we were confident that there would be a health care reform bill at the time that we split those projects and placed them that way.

As you know, the deficit reduction limits that are being held to, force us to a dollar limit on the appropriations side. And, it seemed reasonable then to place those projects, the ambulatory care projects, because there's clearly a focus on reform in the direction that we wanted to go into the investment fund.

If the investment fund doesn't become a reality and health care reform doesn't become a reality, I don't think that the dollar amount that we would have had to live with would have changed at all, and we'll have to take a look at those projects under the 1996 budget if the investment fund doesn't become a reality.

Mr. SMITH. Is your testimony you would not have been up here asking for more money in the construction budget?

Mr. MILBRANDT. The VA submitted a budget to OMB that included both the $115 million and $141 million that's in the appro-

priations and the eight ambulatory care projects as a part of our appropriation. But, due to the deficit reduction limitations, only the amount and projects that you saw were left in the appropriation.

Mr. SMITH. How fluid, or how flexible are you in reconvening those working groups, again, should a whole different set of scenarios present itself?

Dr. HEADLEY. Hopefully, much of the planning that we have done directed at veteran health care is valid planning, and would stand.

I think that if we need future planning activities, we would be able to reconvene, perhaps, smaller groups if we needed. You know, the plan is not yet finished. The plan will not be finished. The plan is an evolving plan, and it is designed to address change.

I think we have recognized from the beginning that there were likely to be some changes in the way health care finally, health care reform finally played out, and I believe that the plan was devised to be flexible.

Mr. SMITH. Can I again ask you on behalf of the Committee, certainly the Minority side, and I'm sure the Majority would like it as well, since there should be no secrets, if it's just a simple fact that the Secretary has not seen the draft or the document, please make that available to us. Again, the time crunch is becoming a real burden, and we need to know exactly what you are thinking so we can analyze it appropriately without, you know, an 11th hour attempt to try to make heads or tails out of it. So, please, if you could make that available to us within the next week I'd appreciate that.

Dr. HEADLEY. I will certainly convey that.

Mr. ROWLAND. Mr. Buyer.

Mr. BUYER. Thank you, Mr. Chairman.

I want to return to the question about the construction projects. The question was, first we had two construction projects, one in West Virginia, one in Oregon, one was scored 380, or 280 out of 380, and the other one wasn't on the list, and now when a request was made for the top 100, all of a sudden those two projects show up in the top 100. Testimony was that that was at the request of Minority Staff, then Mr. Milbrandt said he wasn't sure what the answer was. If you could tell me how those two projects now ended up in the top 100 list, because this country lawyer here has got a little problem.

If the Secretary's testimony on the 9th of March was correct, okay, and we said what his testimony was, and then if Minority Staff requests for the top 100 list after March 9th, and you testified that this list—that they were included because of Minority Staff, and you provide it to us, this is dated March 1st.

So, if you could clarify that for me.

Ms. KURZ. We were asked to provide a list of the current high-priority projects and include on this list those projects that we requested in 1995, so that a comparison could be made.

Mr. BUYER. Who requested that?

Ms. KURZ. That's what you have in front of you.

Mr. BUYER. Who requested that?

Ms. KURZ. I don't know the person specifically. I know that it was called staff.

Mr. BUYER. None of those projects were given any higher score, were they not?

Ms. KURZ. They were not given any higher scores.

Mr. BUYER. No.

Ms. KURZ. The list that the Secretary had as a reference was an inventory list from 1991.

Mr. MILBRANDT. It included all of the projects.

Mr. BUYER. Oh, all right.

Ms. KURZ. And, every year this inventory list is updated by virtue of submission of projects through five year facility plans by each medical center.

Mr. BUYER. As of right now, which is accurate, this list, or the Secretary's testimony on the 9th of March?

Mr. NEARY. Sir, I believe they represent two entirely different things. At the time the Secretary stated that Portland had not been scored, it had not been scored. And, Huntington had been scored in the past. Huntington is a project that the Congress provided design appropriation for in a previous budget and it had been scored.

As a result, when we met with Carl, we discussed the fact that we were validating projects and focusing on ambulatory care, and we were asked to provide a list. We said we had about one hundred of those that we had gone through, and we were asked to provide that list, and to also reflect the projects that were in 1995 for purposes of comparison. It was not to suggest that they should be elevated within our top 100 priorities.

Mr. BUYER. All right, thank you.

Mr. Chairman, if I may, ask one final question, and that is on this issue of independence. I know this is the third time I've come back to it, but we are going to have a seven panel National Health Care Board, and under that we have the Quality Management Council, the 15 members. Then the National Quality Management Council directs the Administrator for Health Care Policy and Research to develop periodic review and update clinically relevant guidelines that may be used by health care providers to assist in determining how diseases, disorders and other health conditions can be effectively and appropriately prevented, diagnosed, treated and medically/clinically taken care of. Now we've got three levels, and we haven't even reached the VA yet.

So, I'm really getting to a question here about the independence of VA, if we don't have any representation anywhere in that three-tiered process. So, my concerns are real, and in your response to me you threw out the Federal Employees Benefits Program, you know. Right now we don't have some national board out there, or some government controls, telling your doctor how to treat you or what the utilization procedure is going to be. You can go out there now, or your HMO might set the utilizations, or what drugs can be used or not used. That's done in the private sector.

If we enact the Health Security Act, it's government control, is that correct?

Dr. HEADLEY. I really can't make that assessment. There are many parts of health care that are currently controlled by various branches of the government. HCFA in its reimbursement sets standards, states set standards. There are quality guidelines that practitioners violate at their danger.

I think that these guidelines already exist. I think that there is a desire through advisory boards, such as the Quality Management

Advisory Board, to set some national standards. I think there are other organizations currently at work setting national standards, such as the Joint Commission and its information.

Mr. BUYER. At any time did you recommend a VA voice be involved in any of these levels of bureaucracy? You helped put this together. Did you ever recommend that VA have a voice or have a position in any of these levels of boards?

Dr. HEADLEY. Karen, I think I'll defer that one to you.

Ms. WALTERS. That was part of our discussion, yes, and we hoped that we would be a member of these boards, the same as any other major practitioner organization. We have also suggested to the veterans' service organizations that they would be representatives as consumers, as major consumer groups.

Mr. BUYER. Can I ask this final question, Mr. Chairman?

The question is, when you were putting this together, did you ever demand that VA have a voice or a seat on any of these boards? I mean, I agree with you about the hope. We are getting ready to move forward with this bill, and if in your discussions or analysis, you felt that that wasn't important, then tell me that, or if you didn't have the political leverage to make that done, we need to know that. I think it's important for us here to discuss whether or not that should be done or not, if you don't think that's important, say it's not important, see.

Dr. HEADLEY. I think that we would have the same obligation to demonstrate the quality and cost effectiveness of our care under this system as any other health care providing organization, such as Kaiser, or any of the large national health care provider organizations.

I think that VA does have special protection, and that should continue. I think that we would be able to develop our supplemental benefits packages for the treatment of service-connected conditions, and I think that these should continue to be national priorities of the VA system.

I can't imagine that a National Health Board would be interested in getting involved with this, as you imply. I just don't see that this would be a role of the National Health Board.

Mr. BUYER. Right, or any other level, so that's why we don't have that voice, right? All right, thank you.

Mr. ROWLAND. Thank you, Mr. Buyer.

I want to thank you for your testimony here this morning, and I urge you to move expeditiously in putting something together that will fit in whatever reform package may finally come out of the Congress. And, please keep this Subcommittee and the full Committee apprised of what you are doing so that we will know and be able to deal with it in a manner that will not be 11th hour.

Dr. HEADLEY. Thank you very much, Mr. Chairman.

Mr. ROWLAND. I thank all of you for coming this morning.

We stand adjourned.

[Whereupon, at 11:52 a.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF HON. CORRINE BROWN

Mr. Chairman, I would like to thank you for holding this series of hearings on the proposed role of the VA health care system under national health care reform. And I would like to welcome Dr. Headley.

Dr. Headley, you should know that I am enormously concerned about the VA's 1995 construction budget. I know you share my concern over the ability of the VA to compete under health care reform, and it is good to know that you are developing a strategy to do so.

As I am sure you are aware of, Florida has the largest veteran population over 65, the second largest population overall, and ranks 43rd in VA per capita funding. The needs of veterans, and in particular the need for adequate facilities for these veterans, should be of utmost importance to the VA.

Let me be perfectly frank Dr. Headley, when I first saw the VA budget last month I was quite upset. What I saw, in this Health Care Investment Fund, was three top-priority projects in my state held hostage to passage of H.R. 3600, while research projects in other states—which were never on the priority list were funded outright in the VA's construction budget.

I can guarantee you this Dr. Headley, if Florida does not get its fair share of VA construction funding, and the VA cannot adequately meet the needs of Florida's veterans, you will see a flight of these brave Americans. They will turn elsewhere for the medical needs.

Dr. Headley, I know you worked with the VA in Gainesville, and understand the unique needs of Florida's veterans. I also know that no other state would benefit more from the VA pilot program, and deserves funding of its ambulatory care projects more than Florida. I trust you agree.

Mr. Chairman, Dr. Headley, I want to thank you for the opportunity to learn what the VA is doing to meet the challenge of competition under health care reform. I certainly hope the VA will have the capability to do so.

STATEMENT OF
DR. ELWOOD J. HEADLEY, ACTING DEPUTY
UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
MARCH 23, 1994

Mr. Chairman and Members of the Committee,

Thank you for this opportunity to tell you about our vision of the new veterans' health care system and the planning now underway to make this vision a reality. For the past thirteen months, VA staff have been working closely with the Administration to define and preserve an independent health care system for veterans that, for the first time, would truly be a choice open to all veterans and their dependents. The Health Security Act proposed by President Clinton is the only health reform bill we have seen which recognizes the unique health needs of veterans and the importance of the VA health system and would preserve and strengthen that system. As the debate in the Congress regarding health care reform continues, we strongly urge that the final legislation contain the provisions regarding veterans' health-care. They represent the best chance for a strong, independent VA health care system capable of providing high quality services responsive to veterans' special needs.

Mr. Chairman, in order to remain a vital, comprehensive health-care system, VA must be able to attract a broader mix of patients. In order to do so, VA must have the opportunity to fairly compete for these patients and be a health care choice for all veterans. As a health plan, VA would be a choice open to all 26.8 million veterans and their 33 million dependents. VA Health Plans would guarantee the comprehensive benefits package to all veterans and their families who enroll with VA. Through this guarantee the President's proposal would enable meaningful eligibility reform by allowing VA to provide a full array of inpatient and outpatient care, prosthetics, durable medical equipment, home health services, hospice care, and drugs to all veterans and their families who elect a VA health plan. Multiple new funding sources would enhance planning and operations for the VA health system.

The Secretary of Veterans Affairs has recognized the crucial need for VA to address the changes we need to make almost immediately to carry out its assigned role under the President's health care reform proposal and to be a competitive choice under national health-care reform. A Health Care Reform Program Office was established last fall and was charged with developing an implementation plan for VA to make the transition to a competitive health care environment. Almost 200 of the VA's most outstanding managers and health care professionals, as well as representatives of Veterans' Service Organizations, worked intensively throughout the month of January to produce the blueprint for this transformation.

Initially, nineteen workgroups were formed to address a broad range of constituency issues, benefits, delivery systems, and management and administrative issues. Members of these workgroups were encouraged to be as creative in their thinking as possible to ensure VA's viability under national health care reform. The workgroups successfully identified many of the challenges before us and proposed a variety of solutions. Subsequently, workgroups with related topics and issues were consolidated into larger groups. For example, the primary care workgroup was combined with the managed care group and charged with defining the components of a comprehensive managed care health delivery system.

The Health Care Reform Program Office is continuing to edit the drafts prepared by the workgroups. An initial draft of the document was presented to the VA Health Reform Board, composed of the Deputy Secretary and other top VA officials, in early March. The final version has not yet been submitted to the Secretary for his review and approval.

Mr. Chairman, because very few individuals in the Department have had an opportunity to review and comment on the report, and because the Secretary has not yet seen it, I cannot share the exact text of the draft document with you at this time. However, I am prepared to discuss the general principles for VA Health Plan operations which have been proposed and the strategies we believe we need to implement to become a competitive choice for veterans and their families.

Mr. Chairman, the workgroups identified two key challenges that will be facing the VA as a health plan provider. First, all levels of the organization must focus on customer service. We truly must change the corporate culture of the VA to develop, value, and reward behavior that puts veterans and their families first. Given universal health coverage, and choice and access to other health care providers, our customers-- veterans and families--will determine by the way they spend their health care dollars whether we are successful in actually changing our culture. To achieve a customer focus, we recognize that we must listen to our customers; tailor our programs to meet their needs; treat them with respect and compassion; and serve them with integrity and quality. I believe that we must include veterans, their families, and their representatives in deliberations at all levels and seek their assistance in the design of their health care system. We have taken the first steps in effecting this culture change by obtaining the views of the Veterans' Service Organizations as we began our planning process.

Because of the importance of this area, the draft report recommends several strategies to systematically change the VA corporate culture to focus on customer service.

The other challenge facing VA under health care reform is the establishment of an integrated managed care delivery system.
Mr. Chairman, our focus in providing care to enrollees in VA Health Plans must center on assuring timely and easily accessible primary care to all enrollees. Primary care is coordinated care for health promotion and disease prevention; acute chronic and specialty care; and health education. Depending on the needs of the enrollee, primary care providers may include physicians, nurse practitioners, physician assistants, a health care team, or a

subspecialist. A plan care manager may assist in coordination of services or arrange for alternative care for enrollees with exceptional needs. In order for a VA Health Plan to be an attractive choice, primary care and routine hospital care must be conveniently located for veterans and their families. Existing VA facilities will be only one of many providers in the VA Health Plan delivery network. VA Plans will directly provide veterans' care in VA facilities, and through a broad provider network which may include our affiliated medical schools, community hospitals, community-based professional practice groups, and individual practitioners. Enrollees would have their choice of providers within the VA Plan network. VA Health Plans will have to be responsive to the changing needs of enrollees and to the local marketplace.

A key decision for plan managers will be "make or buy" - whether to provide the service by VA staff or by contract. The Health Security Act, includes liberalized contractual authority for VA which will be necessary in setting up these provider networks. It may be useful for local managers to have the flexibility and authority to make decisions to buy, lease, or contract for needed equipment, and space to meet enrollee needs. VA has already taken some steps toward improving its delivery of primary care. These efforts will be expanded and accelerated. The next phase will most likely involve establishing provider networks, creating utilization management models and criteria, and conducting actuarial analyses to project demand and cost for services.

H.R. 3600 would also provide VA with the authority to implement alternative personnel systems for the management of VA health personnel. Our Human Resource workgroup recognized that the quality of our workforce was of paramount importance. Many of the recommendations stemming from Vice President Gore's National Performance Review served as a starting point for discussions.

Organizational, administrative, financial management and information resource decision making authority would be decentralized to the lowest level that is feasible. VA Plans would receive input from representatives of plan members, VSOs, the academic and research communities, providers and VA facility managers.

We believe the Secretary's decision to establish Veterans Service Areas (VSAs) is an important first step and that there will be a natural migration of VSAs to Veterans Health Plans.

It has been proposed that each VA Health Plan will develop a detailed business plan, including a financial plan to guide operational decision making at all organizational levels. Business plans would serve as the blueprints for financial management and for establishing both short- and long-term priorities. The business plan would set out the plans' funding needs and proposed use of resources. They would also outline a strategic plan of action for the organization incorporating specific information on marketing, demographics, and investment strategies and be the basis for justifying capital and infrastructure requests. Business plans will be evaluated based on technical merit, soundness of marketing plan, and contribution to the overall VA mission. Plans would be dynamic and be changed accordingly

would be dynamic and be changed accordingly to remain responsive to customer needs. Our next efforts will focus on developing a business planning methodology for all of the VHA to be initiated in FY 1995.

H.R. 3600 includes a Health Care Investment fund that will provide $1.0 billion in Fiscal Year 1995, $.6 billion in Fiscal Year 1996 and $1.7 billion in Fiscal Year 1997 to the VA. This investment fund is intended to help ensure the VA health care system competes effectively.

Mr. Chairman, the President's health reform proposal provides an excellent opportunity to reinvent the VA health system to improve service to the nation's veterans. Thus, V A is taking a comprehensive look at the way we currently deliver services and is developing a comprehensive plan of action that, we believe, will make VA health plans a competitive and preferred choice for millions of veterans and their families.

VHA HEALTH CARE REFORM

CUSTOMER SATISFACTION SURVEY

MARCH, 1994

EXECUTIVE SUMMARY

INTRODUCTION

In February, 1994, VA's Health Care Reform project office commissioned a market research firm to survey current and former VA patients, as well as veterans that have never used VA. The survey questionnaire was approved by OMB (control number 2900-0548) under blanket authority granted to VA for implementation of Customer Satisfaction Surveys (Executive Order 12862).

The purpose of the survey was to analyze the preliminary demand, or market potential for a veteran health plan. It identifies preliminary marketing data that will help guide strategic thinking and provide direction for a more comprehensive baseline study to be conducted later in 1994.

METHODOLOGY

Fifteen hundred (1,500) veterans were telephone-interviewed between February 19 and February 28, 1994. The targeted interviews were split between current users of VA medical services (used VA health system within past year), former users (have not used the health system in the past year), and a random group of non-users (never used VA health system) controlled for location around current and former users.

The listings for current and former users were generated randomly from 143 of the 171 medical centers. A random sample from that master list of twelve thousand names was used as the base. Random-digit dialing was used to contact non-users and it was found that about one in seven households had a veteran. Respondents from 49 of the 50 states are included in the survey. The distribution of inpatient/outpatient is as follows:

	CURRENT USERS	FORMER USERS
Inpatient	22%	24%
Outpatient	33	50
Used both	45	26

Ninety-five percent (95%) of the respondents are male and the median age of the sample is 60.2 years.

PRINCIPAL FINDINGS

- Rating VA health care services on a 1 - 5 scale (5 being excellent), current users rate it highest -- 72% gave it a 4 or 5 rating -- compared with 61% for former users and 35% for non-users. Those over 45 years of age rate the health services higher than those younger. While income level does not affect current users' ratings, low income former and non-users give VA higher ratings.

- When asked to rate VA on ten specific customer service attributes, current users give the highest ratings on all ten, former users next highest and non-users lowest on each one. It is a positive sign that those who know the service first hand are much more favorable. It represents a communication/image lag that non-users are skeptical of the VA's performance.

- Cleanliness of the facilities; courtesy and respect shown by the staff; safety of locations and the nursing staff are the highest rated attributes. The lowest are: waiting time for a scheduled appointment and convenience of the locations.

- In line with the attitudes of the three groups, current users are more likely to opt for VA health insurance over a private health plan (assuming no change in cost) than either former or non-users of VA health care.

	CURRENT USERS	FORMER USERS	NON-USERS
Select VA	66%	47%	27%
Select other	26	44	63
Undecided	8	9	10

  Inpatients, those using VA over 5 years, and those over age 45 are subgroups that have above-average interest in VA insurance. Among non-users, those under 45 are more amenable to VA insurance.

- There is probably some favorable VA bias since respondents are aware of the survey's sponsorship and there is generally a gap between what respondents say and what they'll do when it comes to purchasing a new product or service. Additional factors that will influence the actual outcome include:
  - the extent and intensity competitors market themselves
  - the extent and competence in which VA markets itself
  - the pricing of VA plans versus competing plans
  - the actual delivery network

- Quality of care is a leading reason for choosing VA insurance. Reasons for choosing a private plan include: quality of care, poor VA location, lack of trust in VA and satisfaction with present provider.

- There is price sensitivity in selecting a health plan. Among veterans who selected a private plan, a substantial proportion in each of the three groups would change their choice to the VA plan if VA's plan offered a cost advantage.

	CURRENT USERS	FORMER USERS	NON-USERS
Would still choose private plan	39%	50%	48%
Would switch to VA	51	43	40
Don't know	10	7	12

To attract most of these switches, the VA cost advantage would have to be 10%.

- VA's commitment to veterans' needs is a positive influence for all three groups but especially for users.

	CURRENT USERS	FORMER USERS	NON-USERS
Positive influence	63%	50%	30%
Negative influence	8	10	13
No influence	29	40	57

- There is a strong positive reaction to a family option plan which would permit veterans to be treated by the VA or by community providers and dependents to be treated by community providers.

	CURRENT USERS	FORMER USERS	NON-USERS
Positive influence	60%	53%	52%
Negative influence	7	8	8
No influence	33	39	40

- A demographic profile of the three groups follows:

	CURRENT USERS	FORMER USERS	NON-USERS
Household size	2.4	2.5	2.5
Median age	61.8	61.3	57.2
Have health care coverage (other than VA)	56%	74%	83%
Have Medicare	61%	40%	22%
Employed full-time	18%	27%	50%
Retired	67%	62%	41%
Median income	$17,904	$23,941	$34,535

- Current users travel 79 minutes on average to reach a VA facility and do so about 6.5 times a year.

- Former users last visited a VA facility an average of seven years ago (median three years ago).

- Current users have been using VA health services an average of 13 years while former users had done so for 9. Inpatients have longer periods of use than outpatients.

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PURPOSE AND METHOD

The purpose of this study is to obtain an initial assessment of veteran satisfaction with VA medical services and to obtain a measure of veterans' loyalty to the system, if and when, alternative choices become available. An objective was to differentiate opinions by current users, former users, and veterans who had never used the system.

Telephone interviews were used in order to meet time constraints and to obtain a more representative response than a mail survey might provide. There were 1,500 telephone interviews completed between February 19 and February 28, 1994. The interviews were split between 500 current users of VA medical services, 500 former users, and a random group of non-users controlled for location to match current and former users.

The survey instrument was designed in consultation with VA representatives. The initial survey draft was tested and VA representatives participated in the debriefing of the test interviewers. The instrument was revised for clarity and understanding.

The lists of potential respondents supplied by Veterans Affairs were generated by taking extracts from the 85-gigabyte Integrated Patient Data Base (IPDB) Oracle Relational Database Management System located at the Hines Information Systems Center. Initial screening of the database using PL/SQL and SQL*Plus identified those veterans falling under the following four categories:

- Veterans seen during FY93 and the first four months of FY94 at a VA facility as an Outpatient only.
- Veterans seen during FY93 and the first four months of FY94 at a VA facility as an Inpatient, but could be an outpatient as well.
- Veterans who were seen in a VA facility as an Outpatient only prior to February, 1991 and has no further inpatient or outpatient activity reported as of February, 1994.

- Veterans who were seen in a VA facility as an Inpatient prior to February, 1991 and has had no further Inpatient activity reported as of February, 1994.

Once these veterans were identified, a random selection routine was developed to select veterans for an interview. The total number of veterans fitting the criteria for each category was divided by 6,000. The resulting quotient was used as n, and every nth record was selected for inclusion in the extraction routines which were then sent to the appropriate facility to gather names and phone numbers.

Lists from Veterans Affairs had 14,696 potential respondents with roughly 3,700 respondents in each of four segments--- current inpatients, current outpatients, former inpatients, and former outpatients. As the quota was 250 interviews in each segment, a random sample was taken from the VA disk of 1,500 in each segment or 6,000 potential respondents. This insured random selection across the files provided.

Current users were defined as veterans who had used VA medical services over the past year. The quota for this group was 500 equally divided between in-patients and out-patients.
A random sample with names and phone numbers of current in-patients and current out-patients was supplied by Veterans Affairs. Quota was based on the list source although some interviews were moved to other categories after the interview.

Former users were defined as veterans who had used VA medical services more than 12 months ago. The quota was 500 equally divided between in-patients and out-patients.
A random sample with names and phone numbers of former in-patients and former out-patients was supplied by Veterans Affairs. Quota was based on the list source although some interviews were moved to other categories after the interview.

Non-users were defined as veterans who had never used VA medical services.

Veterans and their use of VA medical services were identified by screening household members nationwide. Phone contact was made through a random digit dial technique. The technique also controlled for location by having random calls made into exchanges where other veterans had used VA medical services. This method is superior to a completely random sample listing because it ensures that veterans in these areas were not so isolated that VA medical services could not be accessed. Lack of access for non-use of VA medical services was not considered actionable for purposes of the present study.

Veterans contacted randomly who were current or former users were interviewed and used to complete quotas of users. The random method used was to add an incremental number to the last digit of a random sample of current and former users. This procedure was preferable to a listed sample because veterans with unlisted numbers were included.

Quotas were also imposed by time zone. The objective was to match the percentage of completed interviews with the sample provided from Veterans Affairs. Following is the summary distribution of sample and interviews by time zone. Random interviews resulted in interviews with residents of every state, except Nevada.

	TOTAL SAMPLE	INTERVIEWED
EASTERN STANDARD	49.9%	50.4%
CENTRAL	34.5	34.1
MOUNTAIN	3.4	3.6
PACIFIC	12.1	11.8

The furnished sample included station numbers which represent VA medical facilities throughout the country. A table of the sample and interviews by station number has been provided in the Appendix and indicates how the interviewed sample is representative of the one supplied by the VA.

Preliminary tabulations were completed and reviewed on March 3rd. Subgroups were recommended for analysis in the final report and are included in final tabulations.

Using a sample of 500 random interviews, results are accurate at a 95% confidence interval within ± 5%. In comparing two samples with 500 random interviews in each, differences are significant when they exceed 8%.

HEALTH CARE REFORM CUSTOMER SATISFACTION SURVEY
SAMPLE DISPOSITION

	Current Inpatient	Current Outpatient	Former Inpatient	Former Outpatient	Total List Sample	Random Digit Sample
Disconnected/Not in Service	146	60	247	311	764	3,966
No Answer/Answer Mach.	188	162	137	311	798	5,979
Non Quota/No Medical Service (List)	9	14	20	69	112	
Non Quota/No Veteran (Random)						4,858
Terminate User of Medical Services (Random)						91
Wrong Number	184	54	94	377	709	
Non-Residential Number						1,297
Not Available/Callback	116	95	52	82	345	622
Refused	45	44	44	121	254	655
Deaf/Language/Incapacitated	43	10	10	4	67	60
Deceased	65	4	54	103	226	
Nursing Home/Hospital #	221	3	115	20	359	
Interviewed	198	196	198	194	786	725*
Total	1,215	639	971	1,592	4,417	18,253

* 503 Non Users
109 Current Users
103 Former Users

VETERAN MEDICAL SERVICE USAGE

In random contact of residents nationwide, 14% of households had a veteran. Veterans made more use of VA Medical Services than other services available to them.

USE OF VA SERVICES
AMONG THOSE RANDOMLY CONTACTED

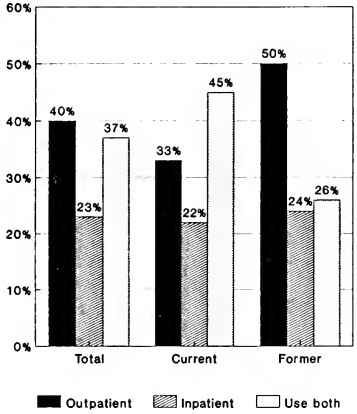
	TOTAL VETERANS
Medical Care Benefits	38%
Education Benefits	35
Home Loan Benefits	28
Rehabilitation/Compensation Benefits	8
Sample Base	(724)*

*Medical Service users included 48 respondents who had to be prompted to qualify as a user and 91 respondents screened for medical service usage, but not interviewed.

The quotas of contacts for users of VA Medical Services based on VA lists were 500 current users and 500 former users evenly split among inpatients and outpatients. Segments were divided based upon veteran responses and reflected a greater representation of current users and inpatients.

Question 3: (If have received medical care from VA), whether you have been an inpatient or outpatient.

VA MEDICAL SERVICES
INPATIENT/OUTPATIENT COMPOSITION



Current users, by definition, had used VA Medical Services over the last year. Former users last used VA Medical Services an average of seven years ago and a median of three years ago.

Question 4: How long ago did you last use any VA health care services?

	TOTAL FORMER USERS	INPATIENT	OUTPATIENT ONLY
1 - 2 years ago	34%	37%	31%
3 - 4 years ago	30	23	36
5 - 9 years ago	15	17	14
10 years or longer	21	23	19
Total	100%	100%	100%
Sample Base	(420)	(212)	(208)
Mean (Years)	7	8	6

Current users of VA Medical Services travel an average of 79 minutes to reach their VA medical facility.

Question 5: How long does it usually take to get to their facility?

	TOTAL CURRENT USERS	INPATIENT	OUTPATIENT ONLY
Less than 30 minutes	19%	18%	23%
30 - 44 minutes	16	15	16
45 - 59	10	8	14
1 hour	18	18	18
1 - 2 hours	12	12	11
2 hours	11	12	9
Over 2 hours	14	16	9
Total	100%	100%	100%
Sample Base	(584)	(390)	(194)
Mean (Minutes)	79	87	64

Current users used VA Medical Services an average of 6.5 times over the last year. As might be expected, inpatients used medical facilities more often than outpatients.

Question 6: In the past year, how frequently have you used VA for health services or testing?

	TOTAL CURRENT USERS	INPATIENT	OUTPATIENT ONLY
Used once	26%	28%	21%
Twice	17	16	20
3 - 4 times	22	20	28
5 - 9 times	16	14	19
10 - 19 times	13	15	8
20 or more	6	7	4
Total	100%	100%	100%
Sample Base	(580)	(388)	(192)
Mean	6.5	7.2	5.1

Current users have used VA Medical Services longer than former users and inpatients have used VA Medical Services longer than outpatients.

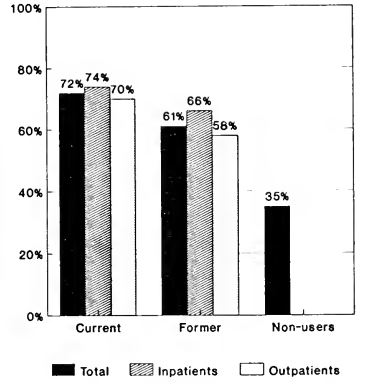
Question 7: For about how long (have you been using/did you use) VA for health services?

	CURRENT USERS			FORMER USERS		
	TOTAL	INPATIENT	OUTPATIENT	TOTAL	INPATIENT	OUTPATIENT
Less than 1 month	2%	2%	2%	15%	14%	17%
1 month - 1 year	8	8	9	8	6	11
1 - 2 years	12	10	17	9	6	13
2 - 5 years	15	11	23	22	22	22
5 - 10	15	18	9	11	12	11
10 - 20	22	23	17	17	20	14
20 + years	26	28	23	18	20	12
Total	101%	100%	100%	100%	100%	100%
BASE	(577)	(387)	(190)	(412)	(208)	(204)
Mean	13	14	11	9	10	7

PERCEPTIONS OF VA HEALTH CARE SERVICES

Not surprisingly, current users are more satisfied with VA health care services than are former and non-users. Also, inpatients in both the current and former user groups are slightly more satisfied than are outpatients.

PERCENT SATISFIED* WITH VA HEALTH CARE SERVICES



* 4 and 5 ratings on a 1 - 5 scale

RATINGS ON VA MEDICAL SERVICES ATTRIBUTES

Respondents rating several specific aspects of VA health care services. While current users gave the highest satisfaction ratings for each attribute (former users were next highest and non-users lowest on each of the attributes), all user groups ranked the attributes in nearly the same order. Appearance and cleanliness of facilities and courtesy and respect shown by the staff received the highest rating while respondents were clearly least satisfied with waiting time for a scheduled appointment and location convenience.

RATINGS ON VA MEDICAL SERVICES

(% Satisfied)*

	CURRENT USERS	FORMER USERS	NON-USERS
Appearance/Cleanliness of facilities	88%	80%	56%
Courtesy & respect shown by staff	84	79	60
Safety of locations	84	72	52
Nursing staff	83	71	47
Comfort of facilities	80	69	46
Filling prescriptions	79	69	44
Quality of physicians	76	68	49
Handling records	75	70	40
Convenience of locations	64	57	46
Wait time for scheduled appointment	52	45	25

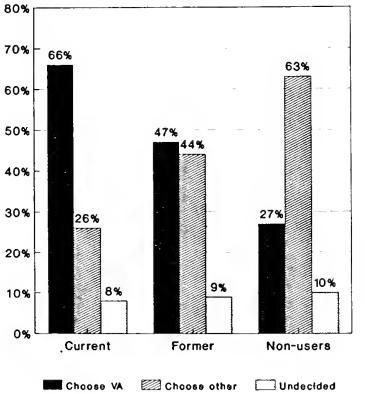
*4 and 5 ratings on a 1 - 5 scale.

CHOICE OF HEALTH CARE PROVIDER

Assuming no difference in cost, most current users of VA health care services (66%) would choose the VA if they had a choice between VA sponsored health care coverage and coverage from some other private plan. Former users are split almost evenly while non-users are much more likely to choose a private health plan.

Question 10: *The government is considering changes that would affect health care options. If there were no change in the cost to you, and you were offered a choice between either health care coverage sponsored by the VA which would include a network of community providers, or one from some other private health plan, for example, Blue Cross, Kaiser-Permanente, or some other HMO, which one would you be most likely to choose -- VA or some other private plan?*

CHOICE BETWEEN VA AND OTHER HEALTH CARE PROVIDER



Quality of care is a major reason volunteered for choosing the VA or fpr selecting an alternative. Interestingly, current and former users of the VA service, those with first hand experience, seem particularly happy with the care they receive.

Main reasons for choosing a private plan (other than good service) are better locations and doubts about quality of the VA staff. Negative experiences with VA are also a deterrent for choosing the VA plan.

Mentioned most by respondents who were undecided on their choice of plan was not having enough information to make a choice.

Question 11: If chose VA sponsored health care coverage, reasons for that choice.

REASON FOR CHOOSING VA

	CURRENT USERS	FORMER USERS	NON-USERS
Good service/Quality care/Happy with them	67%	72%	39%
Facilities especially for Vets	11	11	26
No experience with other plans	11	9	4
Well qualified doctors/staff	9	11	8
Specialty care for Vets	5	2	1
Close to where I live	4	8	7
Don't like other plans	4	3	15
More benefits/coverage/feel secure	4	2	6
Other	2	1	2
Don't know	1	1	4
Total	118%	120%	112%
BASE	(388)	(196)	(135)

Question 11: If chose private health care plan/HMO, reasons for that choice.

REASONS FOR CHOOSING PRIVATE PLAN

	CURRENT USERS	FORMER USERS	NON-USERS
Better quality of service/care/coverage	32%	26%	20%
Location of VA not convenient	29	26	13
Better quality staff/expertise	19	8	6
Don't trust/like VA/bad experiences	18	25	26
Like current provider/private doctor	12	15	32
More variety/choice of doctors/facilities	10	12	1
No experience with VA/not eligible	2	0	10
Other	2	1	2
Don't know	0	2	1
Total	124%	115%	121%
BASE	(154)	(184)	(318)

Both the VA's commitment to the specialized needs of veterans and the option of a family coverage plan have a positive influence on whether respondents would choose the VA as a health care provider. It is striking that non-users are nearly as likely as current and former users to be positively influenced by the option of family coverage, as shown below. Respondents focused more on the advantage of family coverage than on the potentially negative aspects of the veteran being treated in a VA facility and the family member being treated in a different facility.

Question 12: *Does VA's commitment to the specialized health needs of veterans have a positive, negative, or no influence in your consideration of them as your health care provider?*

	CURRENT USERS	FORMER USERS	NON-USERS
Commitment to health needs of vets has positive influence	63%	50%	30%
Has negative influence	8	10	13
Has no influence/neutral	29	40	57
Total	100%	100%	100%
BASE	(584)	(417)	(498)

Question 13: *What if VA also offered the option of a family coverage plan, in which veterans could be treated in either VA or community facilities, and dependents would be treated by community providers. Would this option have a positive, negative, or no influence upon your decision about whether to choose VA or not?*

	CURRENT USERS	FORMER USERS	NON-USERS
Option of family coverage plan has positive influence	60%	53%	52%
Has negative influence	7	8	8
No influence/neutral	33	39	40
Total	100%	100%	100%
BASE	(582)	(418)	(500)

Cost is a major factor, particularly among current users of VA medical services, in choosing a health care provider. When those who opted for a private plan were asked if they would still make that choice if it cost more than the VA plan, one half of current users indicated they would decline to do so. Of those who still would choose a private health plan even if it cost more, most would be willing to pay up to 10% more for the plan; 20% of current users would pay up to 25%.

Question 14: *What if it cost you <u>more</u> to choose another health care plan than it would cost to use the VA system, would you still choose that provider?*

	CURRENT USERS	FORMER USERS	NON-USERS
Yes, would still choose provider other than VA	39%	50%	48%
No, would not	51	43	40
Don't know	10	7	12
Total	100%	100%	100%
BASE	(200)	(224)	(368)

Question 15: *In percentage terms, how much more would you be willing to pay for some other plan over VA's-- would you say?*

	CURRENT USERS	FORMER USERS	NON-USERS
Up to 10% more	58%	61%	47%
Up to 25% more	20	22	32
Up to 33% more	0	3	3
Up to 50% more	12	3	9
Up to 75% more	0	2	2
Up to 100% more	5	7	4
More than twice as much	5	2	3
Total	100%	100%	100%
BASE	(79)	(113)	(189)

DEMOGRAPHICS

Most respondents live in a two-person household.

Question 18: Household Size

	CURRENT USERS	FORMER USERS	NON-USERS
One person	18%	17%	16%
Two people	52	48	47
Three	15	15	17
Four	9	12	12
Five or more	7	7	8
Total	100%	100%	100%
BASE	(586)	(418)	(500)
Mean	2.4	2.50	2.54

Roughly three quarters have no children in the household under age 18.

Question 19: Number in household under age 18.

	CURRENT USERS	FORMER USERS	NON-USERS
None	78%	78%	72%
One person	11	11	14
Two or more people	11	11	14
Total	100%	100%	100%
BASE	(578)	(417)	(499)

Non-users were somewhat younger than current and former users.

Question 20: Age of Respondent

	CURRENT USERS	FORMER USERS	NON-USERS
Under 25	2%	0%	2%
25 - 34	5	4	7
35 - 44	11	12	14
45 - 54	16	21	23
55 - 64	24	20	21
65 - 74	33	32	27
75 and older	10	10	6
Total	100%	100%	100%
BASE	(586)	(414)	(497)
Median	61.8	61.3	57.2

More former and non-users than current users have other coverage in addition to VA benefits.

Question 21: Whether have any (other) health care coverage of any type, including Medicare, in addition to VA benefits.

	CURRENT USERS	FORMER USERS	NON-USERS
Yes, have other coverage	56%	74%	83%
No, do not	44	26	17
Total	100%	100%	100%
BASE	(586)	(417)	(502)

Of those who have additional health coverage, current users are more likely to have Medicare, while former and non-users are more likely to have coverage from another private plan.

Question 22: *If have any health care coverage in addition to VA, who provider is.*

	CURRENT USERS	FORMER USERS	NON-USERS
Medicare	61	40	22
Another private insurance plan (HMO, self-insured co., etc.)	37%	50%	65%
Blue Cross/Blue Shield	18	22	27
Medicaid plan	8	4	3
Total	124%	116%	117%
BASE	(327)	(309)	(417)

Current and former users of VA medical services appear to be less educated than non-users.

Question 23: *Last grade of school completed.*

	CURRENT USERS	FORMER USERS	NON-USERS
Less than high school	27%	23%	11%
High school graduate	38	40	42
Some college/technical school	25	21	26
Four year college degree	6	11	15
Postgraduate work	4	5	6
Total	100%	100%	100%
BASE	(584)	(415)	(501)

More non-users than current and former users are employed. Two-thirds of current users are retired.

Question 24: Employment Status

	CURRENT USERS	FORMER USERS	NON-USERS
Employed full-time	18%	27%	50%
Employed part-time	5	6	4
Retired due to age/disability	67	62	41
Full-time student	1	0	0
Not employed	9	5	5
Total	100%	100%	100%
BASE	(585)	(415)	(501)

Current users have the lowest median annual household income of the three user groups.

Question 25: Household Income

	CURRENT USERS	FORMER USERS	NON-USERS
Under $20,000	56%	43%	22%
$20,000 - $39,999	33	38	38
$40,000 - $59,999	7	13	25
$60,000 - $79,999	3	4	8
$80,000 - $100,000	1	1	3
Over $100,000	0	1	4
Total	100%	100%	100%
BASE	(521)	(360)	(448)
Median	$17,904	$23,941	$34,535

Almost all respondents were male.

Question 26: Gender

	CURRENT USERS	FORMER USERS	NON-USERS
Male	95%	96%	96%
Female	5	4	4
Total	100%	100%	100%
BASE	(588)	(420)	(503)

SURVEY INSTRUMENT

Hollander Cohen & McBride 22 West Rd. Ste. 301 Towson, Md. 21204 410-337-2121 #6123

VA MED BENEFITS 5 -1 E -2 C -3 M -4P

Good evening/afternoon. I'm..... of Hollander, Cohen & McBride. We're doing a survey for the Department of Veterans Affairs. (May I speak with [LIST NAME].) [REPEAT INTRODUCTION IF NECESSARY]. This survey is about healthcare, and my listing indicates you have used VA medical facilities for health services or tests. Is that correct? [IF AFFIRMED, CONTINUE; OTHERWISE, TERMINATE.]

IF RANDOM DIAL:
(Is there anyone in your household who is a veteran of the military? May I speak with him/her?) [REPEAT INTRODUCTION IF NECESSARY] This survey is about the healthcare of veterans.

All replies are completely confidential and will be used for research purposes only. THIS SURVEY HAS BEEN APPROVED BY O.M.B. UNDER O.M.B. APPROVAL #2900-0458 AND WILL TAKE APPROXIMATELY 10 MINUTES TO COMPLETE.

START LISTED RESPONDENTS AT Q. 3

TIME BEGUN_____

1. Which of these benefits available from the VA have you used?

		YES	NO
a. Medical care benefits?	10	-1	-2
b. Education benefits?	11	-1	-2
c. Home Loan benefit?	12	-1	-2
d. Rehabilitation or compensation benefits?	13	-1	-2

2. [IF NO TO MEDICAL BENEFITS]
Have you ever received any medical services, either treatment or testing, from a VA hospital or medical center?
20
-1 YES -2 NO---> [SKIP TO. Q. 8]

3. Has the medical care you've received from the VA been as an inpatient, that is, admitted to the hospital for an overnight stay, or only as an outpatient, i.e. come to a clinic for tests or care, or both?
30
-1 INPATIENT -2 OUTPATIENT -3 BOTH

4. How long ago did you last use any VA healthcare services?
40
-01 WITHIN THE PAST YEAR (CURRENT) ____ ____ YEARS AGO (SKIP TO Q. 7)

5. About how long does it usually take you to get to their facility? ____ ____ [ ]MIN [ ]HRS
50 [ ] HOME CARE ONLY

6. In the past year, how frequently have you used the VA for health services or testing?

____ ____ TIMES
60

7. For about how long (have you been using / did you use) the VA for health services?____ ____
70

8. Overall, using a scale of one through five, with one meaning very poor, and five meaning excellent, how would you rate VA healthcare services? (either from your own experience or your impressions.)
80
VERY POOR -1 -2 -3 -4 -5 EXCELLENT

9. Now I'd like you to use the same rating system to rate some specific aspects of VA healthcare services. These ratings can be based on either your satisfaction through actual experience or just your impressions. First the [CHECKED ITEM], using the scale of one through five, with one meaning very poor, up through five meaning excellent, how would you rate [REPEAT 1st ITEM]?

ROTATE		VERY POOR				EXCELLENT	DK
a. overall quality of nursing staff	90	-1	-2	-3	-4	-5	[ ]
b. overall quality of physicians	91	-1	-2	-3	-4	-5	[ ]
c. length of waiting time to be seen when you have a scheduled appt.	92	-1	-2	-3	-4	-5	[ ]
d. appearance & cleanliness of medical facilities	93	-1	-2	-3	-4	-5	[ ]
e. handling of your records	94	-1	-2	-3	-4	-5	[ ]
f. filling prescriptions	95	-1	-2	-3	-4	-5	[ ]
g. courtesy & respect shown by staff	96	-1	-2	-3	-4	-5	[ ]
h. convenience of the medical facilities locations	97	-1	-2	-3	-4	-5	[ ]
i. safety of locations	99	-1	-2	-3	-4	-5	[ ]
j. how comfortable the facilities are	99	-1	-2	-3	-4	-5	[ ]

10. The government is considering changes that would affect healthcare options. If there were no change in the cost to you, and you were offered a choice between either healthcare coverage sponsored by the VA which would include a network of community providers, or one from some other private health plan, for example, Blue Cross, Kaiser-Permanente, or some other HMO, which one would you be most likely to choose--the VA or some other private health plan?
100

-1 VA -2 OTHER -3 DK/UNDECIDED

11. Why is that? _____

111 112 113

12. Does the VA's commitment to the specialized health needs of veterans have a positive, negative, or no influence in your consideration of them as your health care provider?
120

-1 POSITIVE -2 NEGATIVE -3 NONE/NEUTRAL

13. What if the VA also offered the option of a family coverage plan, in which veterans could be treated in either VA or community facilities, and dependents would be treated by community providers. Would this option have a positive, negative, or no influence upon your decision about whether to choose the VA or not?
130

-1 POSITIVE -2 NEGATIVE -3 NO INFLUENCE

**IF CHOOSE -1 VA IN QUES. 10 ABOVE, SKIP TO INTRO TO DEMOS

14. What if it cost you more to choose another health care plan than it would cost to use the VA system, would you still choose that provider?
140
-1 YES/OTHER -2 NO/VA [SKIP TO INTRO TO DEMOS] -3 DK

15. In percentage terms, how much more would you be willing to pay for some other plan over the VA's--would you say....
150
-1 up to 10% more,
-2 up to 25% more,
-3 up to 33% more,
-4 up to 50% more,
-5 up to 75% more,
-6 up to 100% more, that is, twice as much, or
-7 even more than that?

Now, I have a few questions for statistical purposes only.

16. In which state do you live? _____
160

17. Do you consider your neighborhood to be city, suburban, or more country rural?
170 -1 CITY -2 SUBURBAN -3 RURAL

18. Including yourself, how many live in the household? _____[IF "1", SKIP TO Q. 20]
180

19. How many, if any, are under the age of 18? _____
190

20. In what year were you born? ____ ____ ____ ____
200

21. Do you currently have any (other) healthcare coverage of any type, including Medicare (in addition to your VA benefits)?
210
-1 YES -2 NO [SKIP TO Q. 23]

22. Is this through: [CIRCLE ALL THAT APPLY]
220
-1 a Blue Cross/Blue Shield plan,
-2 another private insurance plan, (INCL. HMO, SELF-INSD CO. ETC)
-3 a Medicaid plan, or
-4 Medicare?

23. What is the last grade of school you completed?
230
-1 LESS THAN HIGH SCHOOL
-2 HIGH SCHOOL GRADUATE
-3 SOME (1-3 YRS) COLLEGE OR TECHNICAL SCHOOL
-4 4 YR. COLLEGE GRADUATE
-5 POSTGRADUATE WORK/STUDIES

24. Are you currently....
240

-1 employed full time,

-2 employed part time,

-3 retired due to age or disability,

-4 a full-time student, or

-5 not employed at the present time?

25. Is your household's total income from all sources over or under $40,000?
250

[ ] OVER

Is it between:

-3 40 to 60,000

-4 60 to 80,

-5 80 to 100, or

-6 over that?

[ ] UNDER

Is it between:

-2 20 to 40,000, or

-1 under $20,000?

[ ] REFUSED

26. RESPONDENT IS: -1 MALE -2 FEMALE
260

Thank you very much for your time, information, and opinions. Good night.

TIME ENDED_____

INTV. LENGTH_____

PHONE NO:_____ NAME IF LISTED_____

27. CODE FACILITY NO. IF AVAILABLE _____
270

28. SAMPLE IS FROM: -1 CURRENT INPATIENT LIST -2 FORMER INPATIENT LIST
280 -3 CURRENT OUTPATIENT LIST -4 FORMER OUTPATIENT LIST
-5 RANDOM DIGIT DIALING LIST

INTVR._____

DATE_____

VERIFIED BY_____

DISTRIBUTION OF SAMPLE & INTERVIEWS BY FACILITY

Distribution of Sample and Interviews By Facility

Station Number	Facility Name	Sample Frequency	Completed Interviews
402	Togus	20	0
405	White River Junction	58	7
436	Ft. Harrison	1	0
437	Fargo	88	11
438	Sioux Falls	62	5
442	Cheyenne	30	2
452	Wichita	54	7
459	Honolulu	25	2
460	Wilmington	233	18
463		36	0
500	Albany	100	6
501	Albuquerque	44	4
502	Alexandria	193	20
503	Altoona	267	20
504	Amarilla	86	3
505	Tacoma	86	2
506	Ann Arbor	102	6
508	Atlanta	312	16
509	Augusta	316	15
512	Baltimore	50	4
513	Batavia	6	0
514	Bath	167	10
515	Battle Creek	97	3
516	Bay Pines	144	12
517	Beckley	6	0
518	Bedford	38	0
519	Big Spring	44	1
520	Biloxi	106	3
521	Birmingham	125	4
522	Bonham	42	2
523	Boston	192	16
525	Brockton	66	8
526	Bronx	85	8
527	Brooklyn	303	14
528	Buffalo	23	0
529	Butler	46	1
531	Boise	57	3
532	Canandalgua	56	2
533	Castle Point	320	18
534	Charleston	25	1
535	Chicago (Lakeside)	64	9
537	Chicago (Westside)	43	2
538	Chillicothe	80	7

Station Number	Facility Name	Sample Frequency	Completed Interviews
539	Cincinnati	37	1
540	Clarksburg	6	0
541	Cleveland	324	19
542	Coatsville	67	1
543	Columbia, MO	111	10
544	Columbia, SC	38	3
546	Miami	320	14
549	Dallas	317	14
550	Dansville	98	2
552	Dayton	122	10
553	Allen Park	55	3
554	Denver	55	2
555	Des Moines	55	2
556	North Chicago	61	3
557	Dublin	72	3
558	Durham	138	10
562	Erle	32	4
564	Fayetteville, AR	49	3
565	Fayetteville, NC	41	1
566	Ft. Howard	3	0
567	Ft. Lyon	13	0
568	Ft. Meade	24	1
569	Ft. Wayne	57	3
570	Fresno	50	4
573	Gainesville	159	5
574	Grand Island	24	1
575	Grand Junction	56	1
578	Hines	305	11
579	Hot Spring	18	4
580	Houston	151	12
581	Huntington	60	2
583	Indianapolis	115	10
584	Iowa City	97	9
585	Iron Mountain	53	3
586	Jackson	34	1
589	Kansas City	74	6
590	Hampton	24	1
591	Kerrville	69	3
592	Knoxville	44	2
594	Lake City	109	2
595	Labanon	87	6
596	Lexington	93	11
597	Lincoln	35	4
598	Little Rock	48	6
599	Livermore	55	1
600	Long Beach	341	17

Station Number	Facility Name	Sample Frequency	Completed Interviews
603	Louisville	87	5
604	Lyons	58	3
605	Loma Linda	144	3
607	Madison	110	11
608	Manchester	58	5
609	Marion, IL	75	6
610	Marion, IN	67	4
611	Marlin	17	1
612	Matinez	147	6
613	Martinsburg	107	5
614	Memphis	98	7
617	Miles City	29	1
618	Minneapolis	331	17
619	Montgomery	12	0
620	Montrose	56	1
621	Mountain Home	77	2
622	Murfreesboro	108	0
623	Muskogee	65	1
626	Nashville	65	7
627	Newington	84	5
629	New Orleans	60	5
630	New York	96	7
631	North Hampton	42	1
632	Northport	52	2
635	Oklahoma	148	7
636	Omaha	56	4
637	Asheville	68	3
640	Palo Alto	135	5
641	Perry Point	62	3
644	Phoenix	17	1
645	Pittsburgh (HD)	44	1
646	Pittsburg (UD)	95	4
647	Poplar Bluff	57	0
648	Portland	86	13
649	Prescott	61	2
650	Providence	33	0
652	Richmond	97	3
653	Roseburg	87	3
654	Reno	31	4
655	Saginaw	85	2
656	St. Cloud	62	3
657	St. Louis	332	16
658	Salem	111	4
659	Salisbury	107	3
660	Salt Lake City	93	5
662	San Francisco	133	7

Station Number	Facility Name	Sample Frequency	Completed Interviews
663	Seattle	106	6
664	San Diego	97	1
665	Sepulveda	99	7
667	Shreveport	86	3
668	Spokane	58	2
671	San Antonio	49	2
672	San Juan	17	0
673	Tempa	127	1
674	Temple	111	2
676	Tomah	221	11
677	Topeka	64	0
678	Tuscon	29	0
679	Tuscaloosa	25	3
680	Tuskegee	62	1
685	Waco	56	1
686	Leavenworth	43	0
687	Walla Walla	56	2
688	Washington, D.C.	90	4
689	West Haven	69	2
691	West LA	129	1
692	White City	16	2
693	Wilkes Barre	89	4
695	Milwaukee	270	21
752	LA OPC	23	2
756	El Paso	25	0
757	Columbus OPC	139	6

STATEMENT OF JOHN R. VITIKACS, ASSISTANT DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
TO THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 23, 1994

Members of the Subcommittee:

The American Legion appreciates the opportunity to offer its views concerning the present and future direction of VA construction planning, especially as it relates to national health care reform.

The American Legion believes the VA medical construction program has not been properly funded over many years. If VA is to be a competitive health care provider, changes must be made at both ends of Pennsylvania Avenue. While several new medical facilities have been funded for construction in recent years, it seems that most of the major medical construction budget has been devoted to new facility development and not enough attention has been devoted to existing infrastructure requirements. VA has an archaic medical facility infrastructure. The American Legion has repeatedly testified that the capital plant system of VA is a multi-billion investment of the Federal government that must be maintained in a systematic manner. Now that VA is positioning itself to undertake an extensive health care reform strategy, the impairment of inadequate construction planning and funding of many years threatens the framework of a competitive health care provider.

The American Legion doubts whether VA can seriously admit that the VA medical system's infrastructure is prepared for health care reform. Years of inadequate funding will force VA to utilize resources from the Health Care Investment Fund (Phase I), proposed in H.R. 3600, to build new ambulatory care additions at various medical centers. These facilities should have already been in the planning and funding pipeline. Now VA has some serious catching up to do. At this time it is not clear what other construction projects are being proposed for consideration within the Health Care Investment Fund, Phase 2 and Phase 3.

The American Legion believes this hearing is timely and necessary. For too long, VA has proceeded in developing its construction program in the absence of sound priorities. The Legion's hospital field representatives repeatedly identify serious construction deficiencies during site visits to VA medical facilities. We have testified over the years to the need for a new and expanded ambulatory care/outpatient clinic construction program, for development of new facilities in rapidly growing sunbelt states, for a greater emphasis on rural health care services, to a need for a greater emphasis on long-term care construction, and to the need for an aggressive modernization and renovation program. Fortunately, Congress has funded a number of new construction projects over the years, and for this The American Legion and the veterans of this country are grateful. At the same time, The Legion is astonished that other much needed projects never seem to make the priority construction list. The Legion would like to point out that for years, medical centers in Tampa and Gainesville, Florida; Phoenix, Arizona; Pittsburgh (UD), Pennsylvania; East Orange, New Jersey; and other locations have had increasingly troublesome concerns related to construction deficiencies, which have not received the necessary attention.

The Legion hopes VA will answer this Subcommittee's questions concerning the future direction of the medical

construction program. In particular, why the FY 1995 Health Investment Fund projects do not include construction initiatives for rural locations? Considering construction planning under the Phase 2 and Phase 3 Health Investment Fund years, what plans does VA have regarding the development of primary care clinic locations in geographically inaccessible areas? The Legion would hope VA's future construction plans do not duplicate already existing services and that any criteria established for expanding VA's presence in the community will alleviate long trips by veterans to receive VA medical care.

During the first five months of FY 1994, VA's minor construction program has exhausted its funding for all but the highest priority projects. All minor construction projects have been placed on hold so that the remaining funds can be used in the most critical areas. Yet the proposed funding level for minor construction in FY 1995 is the same as the current fiscal year. It is not difficult to predict that VA's minor construction program will always encounter these same difficulties until the annual funding level is raised to required levels. For FY 1994 major construction, the $115 million in new funding authority not only represents the lowest level in years, but the Office of Management and Budget (OMB) has projected this level of funding for the next five years. Unless VA construction is adequately funded VA cannot develop a sound construction policy. This policy must be needs-based, not budget driven. Years of funding neglect have created too many operational deficiencies. This trend must be reversed if VA is to become a competitive health care provider.

VA will soon transition from its current four medical region alignment in the Veterans Health Administration to the planned 16 Veterans Service Areas (VSAs). The American Legion believes that VA needs to inventory its most critical construction projects and make that information available to this Subcommittee. Secondly, once the transition to the 16 VSAs is complete, a credible proposal on realigning the medical care missions of all VA medical centers must be presented. In our view, VA can then begin to develop a sound construction program, determine the potential impact on veteran beneficiaries, update and complete all Facility Development Plans and establish a firm benchmark ranking schema for addressing the system's most pressing construction needs.

The American Legion is prepared to answer any questions this Subcommittee's members may have on this critical issue.

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